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	290042	A. BUILDING _____ B. WING _____	09/26/2008

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HARMON MEDICAL AND REHABILITATION HOSPITAL	2170 EAST HARMON AVENUE LAS VEGAS, NV 89119

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A 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare recertification survey conducted in your facility on September 23 through September 26, 2008. The following Conditions of Participations were not met: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient's Rights 42 CFR 482.48 Discharge Planning 42 CFR 482.21 Quality Assessment and Performance Improvement The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	A 000		
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on policy and procedure review and staff interview, the facility failed to ensure an effective governing body was legally responsible for the conduct of the hospital. The facility failed to	A 043		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 043	Continued From page 1 protect and promote each patient ' s rights (A-0115); failed to develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program (A-263); and failed to ensure an effective discharge planning process that applies to all patients was in place and the policies and procedures were specified in writing (A-799). The facility failed to comply with Federal Standards listed under the Condition of Participation for Governing Body as evidenced by: the failing to ensure services performed under contract were provided in a safe and effective manner (A0084); and failing to assure medical staff had written policies and procedures for appraisal of emergencies, initial treatment, and referral when needed (A0093). The cumulative effect of these systemic practices resulted in the failure of the facility to deliver statutory mandated care to patients.	A 043		
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on review of quality assurance performance improvement (QAPI) documentation and interviews with the Hospital Administrator, the facility's governing body failed to ensure services provided under contract were provided in a safe and effective manner. Findings included:	A 084		

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A 084	Continued From page 2 Review of the facility's quality assessment and performance improvement program did not reveal that contracted services were included in the QAPI program. In an interview with the Hospital Administrator on 9/26/08 at 1:30 PM, the Administrator reported the hospital did not include contracted services in the QAPI program. The Administrator stated he met with the contracted services representatives quarterly. The Administrator reviewed quality assurance information provided by the contractors yearly but did not have a record of the information available in the facility.	A 084		
A 093	482.12(f)(2) EMERGENCY SERVICES If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: Based on governing body bylaws, medical bylaws, policy and procedure review and staff interview, the facility failed to develop written policies for appraisal of emergencies, initial treatment and referral of persons with emergencies and failed to train staff as to their responsibilities in an emergency situation involving persons who were not patients or residents. Findings include: 1. A review of the governing body bylaws did not address the medical staff's responsibility to develop written policies and procedures for appraisal of emergencies, initial treatment and	A 093		

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A 093	Continued From page 3 referral when appropriate. 2. A review of the medical staff bylaws revealed the emergency care of patients and residents at the hospital was addressed but the bylaws did not address emergency care provided to people seeking help at the hospital who were not patients at the facility (staff, visitors etc.). 3. On 9/23/08 at 10:00 AM, Charge Nurse #12 was interviewed. Charge Nurse #12 was asked what she would do if a visitor collapsed and was unresponsive on the unit. Charge Nurse #12 stated she would call 911. When asked if she would do anything else, the Charge Nurse stated she would not. Charge Nurse #12 was asked if she would call a code if there was no pulse or respirations and the Charge Nurse said she would not because she did not know the person and the medications the person was taking. 4. On 9/23/08 at 10:20 AM, Charge Nurse #9, Licensed Practical Nurse (LPN) #10 and LPN #11 were interviewed. The staff were asked the same question regarding the care of an unresponsive visitor without a pulse or respirations. The staff reported they would assess the person, take vital signs and do cardiopulmonary resuscitation if needed. The staff all agreed they would not call a code but would call 911. The staff reported the ambulance responded quickly to the hospital. The staff did not know of a hospital policy addressing emergency care for visitors, staff or persons seeking emergency assistance. 5. On 9/23/08 at 11:00 AM, the Acting Director of Nursing (DON) was asked for the facility's policy and procedure addressing emergency care of visitors, staff and persons seeking emergency	A 093		

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A 093	Continued From page 4 medical assistance. The Acting DON submitted a policy and procedure entitled "Emergency - 911" that addressed only patient and resident emergency care. Emergency care of visitors, staff and persons seeking emergency medical assistance was not addressed in the policy and procedure. 6. The hospital administrator submitted a second policy and procedure entitled "Emergency Medical Treatment & Active Labor Act (EMTALA) Compliance". The policy and procedure revealed it was originated on 4/08. The policy revealed that any person presenting to the hospital requesting assistance for a potential emergency condition would be evaluated by a Registered Nurse. There was no indication the nurse was to contact a physician. Emergency assistance was to be provided within the scope of the hospital's abilities until appropriate arrangements could be made to transfer the person to an emergency room. The Acting DON was shown the policy and procedure "Emergency Medical Treatment & Active Labor Act (EMTALA) Compliance" at 1:00 PM. The Acting DON stated she had never seen the policy before. The Acting DON stated the policy "pretty much" described what the facility did and reported the staff ran a code on a visitor once. The Acting DON could not explain why the staff nurses did not know of their responsibility to provide emergency care to people who were not patients or residents of the facility. On 9/23/08 at 2:00 PM, the Director of Education was interviewed. The Director of Education reported she had never seen the policy and procedure entitled "Emergency Medical	A 093		

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A 093	Continued From page 5 Treatment & Active Labor Act (EMTALA) Compliance". The Director of Education reported the nurses did not receive training in the policy and procedure during orientation or as an ongoing in-service program.	A 093		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to protect and promote each patient's rights. The facility failed to inform each patient whom to contact to file a grievance (A-0118); failed to ensure the grievance process included a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization (A0120); failed to establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital (A-0121); failed to ensure the grievance process specified time frames for review of the grievance and the provision of a response (A-0122); failed to provide the patient with a written notice of the decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion (A-0123); failed to ensure the patient had the right to participate in the development and implementation of his or her plan of care (A-0130); the facility failed to ensure the patient had the right to the confidentiality of his or her clinical records (A-0147); failed to ensure all patients have the right to be free from restraint or seclusion, of any form, imposed as a	A 115		

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A 115	Continued From page 6 means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time (A-0154); failed to ensure restraints or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm (A-0164); failed to ensure the type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm (A-0165); failed to ensure the use of restraints or seclusion must be in accordance with a written modification to the patient's plan of care (A-0166); failed to ensure orders for the use of restraints or seclusion must never be written as a standing order or on an as needed basis (PRN) (A-0169); failed to ensure the alternatives or other less restrictive interventions attempted have been documented in the patient's medical record (A-0186); failed to ensure the patient has the right to safe implementation of restraint or seclusion by trained staff (A-0194); and failed to ensure the facility reported deaths associated with the use of seclusion or restraints (A-0214). The cumulative effects of these systemic practices resulted in the failure of the facility to deliver statutory mandated care to patients.	A 115		
A 118	482.13(a)(2) PATIENT RIGHTS: GRIEVANCES The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by:	A 118		

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A 118	Continued From page 7 Based on interview and document review, the hospital failed to establish a process for prompt resolution of patient grievances and the facility failed to inform each patient whom to contact to file a grievance. Findings include: 1. A review of the grievance policy titled: "Social Services Grievance/Complaint Process policy SS-82 Original 3/2006." There were no further policy updates provided. Specific timelines were not addressed in the grievance policy. The policy did not include how the patient was informed of the procedure or to whom they were to file the grievance. 2. A review of the grievance policy titled : "Social Services Grievance/Complaint Process policy SS-81 Original 3/2006", stated: " 5....Leadership will furnish a written description of the patient's/resident's legal rights...B. written information identifying the facility's staff members responsible for the Grievance/Complaint Process..." The written information specified in section B (as mentioned above) was unable to be produced during the survey. 3. The "Admission Business/Insurance Packet Hospital" contained a "Bill of Rights" that stated "...12....right to be informed of hospital policies and procedures...right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available..."	A 118		

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A 118	Continued From page 8 The "Admission Business/Insurance Packet Hospital" did not contain information detailing the grievance process specifying with whom to file a grievance. 4. On 9/23/08 in the morning, an interview with the Acting Director of Nursing (DON) and Social Worker (SW), confirmed the policy on grievances and the admissions packet was all the facility had on the subject. 5. On 9/24/08 in the morning, an interview with the SW, confirmed there was no process in place for ensuring the patients were made aware of how and to whom to file a grievance. The SW confirmed there was no written grievance information available to give the patients.	A 118		
A 120	482.13(a)(2) PATIENT RIGHTS: TIMELY REFERRAL OF GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.] The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum: This STANDARD is not met as evidenced by: Based on interview and policy review, the facility failed ensure the grievance policy contained a mechanism for timely referral of patient concerns	A 120		

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A 120	Continued From page 9 regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. Findings include: 1. The "Social Services Grievance/Complaint Process policy SS-82 Original 3/2006", (no further updates were provided) was reviewed and revealed specific timelines for referrals to the Utilization and Quality Control/Quality Improvement Organization were not addressed in the grievance policy. The patient's "Bill of Rights" which is included in the hospital's "Admission Business/Insurance Packet" contained information for the patient's to file a complaint. The names, addresses and phone numbers to the following agencies were provided; the State Survey and Certification Agency, State Ombudsman, Agency for the Protection and Advocacy of the Developmentally Disabled Individual, Agency Responsible for the Protection and Advocacy of Mentally Ill Individuals, and the Agency Responsible for Investigating Medicaid Fraud. There was no information provided on the Quality Control/Quality Improvement Organization. On 9/23/08 in the morning, an interview with the Acting Director of Nursing (DON) and Social Worker (SW), confirmed the policy on grievances (as discussed above) and the admissions packet (given to the patient by the business office) was all the facility had on the subject. On 9/24/08 in the morning, an interview with the SW, confirmed there was no process in place for ensuring the patients were made aware of how	A 120		

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A 120	Continued From page 10 and to whom to file a grievance. The SW indicated there was no specific time frame established for the grievance process. The SW confirmed there was no written grievance information, explaining the process, available for the patients.	A 120		
A 121	482.13(a)(2)(i) PATIENT RIGHTS: GRIEVANCE PROCEDURES [At a minimum:] The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. Findings include: 1. A review of the "Social Services Grievance/Complaint Process policy SS-82 Original 3/2006" did not address specific timelines for submitting a grievance. The policy did not include how the patient was informed of the procedure or to whom they were to file their grievance. The grievance policy stated: " 5...Leadership will furnish a written description of the patient's/resident's legal rights...B. written information identifying the facility's staff members responsible for the Grievance/Complaint Process..."	A 121		

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A 121	Continued From page 11 The written information specified in section B (above) was unable to be produced during the survey. 2. The "Admission Business/Insurance Packet Hospital" contained a "Bill of Rights" that stated "12. ...right to be informed of hospital policies and procedures...right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available..." The "Admission Business/Insurance Packet Hospital" did not contain information detailing the grievance process specifying with whom to file a grievance. On 9/23/08 in the morning, an interview with the Acting Director of Nursing (DON) and Social Worker (SW), confirmed the policy on grievances and the admissions packet was all the facility had on the subject. On 9/24/08 in the morning, an interview with the SW, confirmed there was no process in place for ensuring the patients were made aware of how and to whom to file a grievance. The SW confirmed there was no written grievance information available for the patients.	A 121		
A 122	482.13(a)(2)(ii) PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES At a minimum: The grievance process must specify time frames for review of the grievance and the provision of a response.	A 122		

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A 122	Continued From page 12 This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to establish a process specifying time frames for review of the grievance and to provide a response to the complainant. Findings include: 1. A review of the "Social Services Grievance/Complaint Process policy SS-82 Original 3/2006", did not include specific timelines for reviewing the grievance and responding to the complainant. The policy did not include if or how the patient was informed of the outcome of the grievance. On 9/23/08 in the morning, an interview with the Acting Director of Nursing (DON) and Social Worker (SW), confirmed the policy on grievances and the admissions packet was all the facility had on the subject. On 9/24/08 in the morning, an interview with the SW, indicated there was no process in place to provide a response to the patient of the outcome of the grievance.	A 122		
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.	A 123		

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A 123	Continued From page 13 This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notice of its decision containing the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of investigation completion was provided to the patient. Findings include: 1. A review of the "Social Services Grievance/Complaint Process policy SS-82 Original 3/2006", did not include if or how the patient was informed of the outcome of the grievance. The policy did not address the patient receipt of a written notice of grievance outcome. On 9/23/08 in the morning, an interview with the Acting Director of Nursing (DON) and Social Worker (SW), confirmed the policy on grievances and the admissions packet was all the facility had on the subject. On 9/24/08 in the morning, an interview with the SW, indicated there was no process in place to provide a written response to the patient of the outcome of the grievance.	A 123		
A 130	482.13(b)(1) PATIENT RIGHTS:PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by:	A 130		

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HARMON MEDICAL AND REHABILITATION HOSPITAL	2170 EAST HARMON AVENUE LAS VEGAS, NV 89119

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A 130	Continued From page 14 Based on interview and document review, the facility failed to ensure the patients exercised their right to participate in the development and implementation of their plan of care. Findings include: 1. The Patient's "Bill of Rights" stated "...3. The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and hospital policy and to be informed of medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services that the hospital provides or transfer to another hospital. The hospital should notify patients of any policy that might affect patient choice within the institution..." 2. The "Patient Care Plan Policy 341km (issued 4/05 and revised on 4/07)" stated: "...Care Plans are initiated for each patient by the Registered Nurse (RN) assigned to admit them. These are initiated upon admission or no later than 24-hours after admission. Care plans are to be maintained in a binder at the Nurse's Station and are updated as patient's condition changes. Charge RN, will acknowledge review of care by initialing in the indicated section. All items must be resolved by discharge, if they are resolvable. Upon patient discharge, Care Plans must be completed and filed in the Medical Record before being sent to the Health Information Department (Medical Records Department). Clinical Directors will address the Case Management Section of the Care Plan and update as changes in the Plan are determined..."	A 130		

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A 130	Continued From page 15 On 9/26/08 at 9:30 AM, the Acting Director of Nursing (DON) indicated the nurse completes the care plan. The Acting DON indicated the patient and/or family was not involved in the care plan process.	A 130		
A 147	482.13(d)(1) PATIENT RIGHTS: CONFIDENTIALITY OF RECORDS The patient has the right to the confidentiality of his or her clinical records. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect the privacy of patients for two of 36 patients (#9, #14). Findings include: Patient #9: The patient was admitted to the facility on 8/28/08, with diagnoses that included Chronic Respiratory Failure, Anxiety State and Pneumonia. On 9/24/08, a photograph of Patient #9's buttocks was observed on the nurses station counter top. The photograph was one of four photographs on the counter top. The patient's buttocks and ulcers were clearly visible in the photograph. The patient's name was written in large letters that could easily be read from several feet away. Wound Care Nurse (WCN) #13 was interviewed on 9/24/08. WCN #13 was told he had left the photograph where passersby could see them. WCN #13 stated that he had made a mistake in not protecting the patient's privacy. Patient #14: The patient was admitted to the	A 147		

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A 147	Continued From page 16 facility on 9/23/08 with diagnoses that included Paraplegia, Myopathy and Dysphagia. Patient #14 was noted to have a decubitus ulcer on admission to the hospital. On 9/24/08, a photograph of Patient #14's sacral area was observed on the nurses station counter top. The photograph was one of four photographs on the counter top. The patient's wound could be easily seen by people walking by the nurses station. The patient's name was written under the photograph and could be easily seen from several feet away. Wound Care Nurse #13 was interviewed on 9/24/08. WCN #13 was told he had left the photograph where passersby could see them. WCN #13 stated that he had made a mistake in not protecting the patient's privacy	A 147		
A 154	482.13(e) USE OF RESTRAINT OR SECLUSION Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. This STANDARD is not met as evidenced by: Based on interview, record review and document review, the facility failed to ensure a restraint was used for the prevention of immediate safety and was discontinued at the earliest possible time for 4 of 36 patients (#1, #28, #29, #30).	A 154		

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A 154	Continued From page 17 Findings Include: Patient #1 was admitted to the facility on 12/28/07 and discharged on 1/16/08 with diagnoses including Pneumonia; Hypertension; Debility; and Other Mental Condition 1. Restraint Orders - 12/29/07; time 10:05; duration 24 hour; type Vest; reason: trying to get out of bed/hx (history) of fall. - 12/31/07; time 0700 (7:00AM); duration 24 hour (hr); type PV (Posey vest); reason: climbs out of bed no safety awareness. - 12/30/07; time 0700; duration 24 hr; type Posey vest; reason: climbs out of bed no safety awareness. - 1/07/08; time 0700; duration 24 hr; type PV; reason: climbs out of bed no safety awareness. - 1/8/08; time 0700; duration 24 hr; type PV; reason: climbs out of bed no safety awareness - 1/12/08; time 0800 (8:00AM); duration 24 hr; type Posey vest; reason: attempts to get out of bed without assistance, fall precautions. - 1/16/08; time 0800; duration 24 hr; type PV; reason: attempts to get out of bed without assistance, fall precautions. 2. The forms specified in the policy (Titled: Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12) were not in the patient's record. The forms were the Physical Restraint Assessment, Physical Restraint Follow-Up, Restraint Chart Checklist, Informed Consent Restraint Use, Interdisciplinary Care Plan Physical Restraint, and the Restraint Tracking/Trending Log. 3. The record contained no documented	A 154		

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A 154	Continued From page 18 evidence less restrictive measures and alternatives were tried. 4. The record contained no documented evidence reassessment to terminate the restraints was completed during the 2 hour removal and repositioning period. 5. The care plans were not updated to include the use of restraints. 6. There was no consent forms, authorizing the use of restraints, in the record. Patient #28 was admitted to the facility on 9/17/08 with diagnoses including Altered Mental State; Depressive Disorder; Hypertension; Anxiety State; Other Chronic Pain; Pneumonia, Hypertension; Debility; and Other Mental Condition 1. Physician's Orders: An order was written on 9/23/08 at 0800 (8 AM), "Posey Vest for pts' (patient's) safety." The policies and procedures, listed below, specified: - The Pink Physical Restraint Order Sticker was to be placed on the physician's order sheet. - "For Safety" was not an acceptable rational for restraint use. - There was no specifications of duration. The pink sticker containing the physician's order for restraint was not in the chart. 2. The forms specified in the policy (Titled: Nursing Policies and Procedures, Restraint,	A 154		

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A 154	Continued From page 19 original: 3/2006; NP - R - 5 through 12) were not in the patient's record. The forms were the Physical Restraint Assessment, Physical Restraint Follow-Up, Restraint Chart Checklist, Informed Consent Restraint Use, Interdisciplinary Care Plan Physical Restraint, and the Restraint Tracking/Trending Log. 3. The record contained no documented evidence less restrictive measures and alternatives were tried. 4. The record contained no documented evidence reassessment to terminate the restraints was completed during the 2 hour removal and repositioning period: 0800 (AM); 1000 (10 AM); 1200 (noon); 1400 (2 PM); 1600 (4 PM); 1800 (6 PM); 2000 (8 PM); and 2200 (10 PM). The "Restraints" portion of the 9/24/08 "Patient Care Record" indicated staff initialed off at eight 2 hour intervals. There were only 2 written entries made in this section: A. "Pt (patient) attempts to get out of bed, unsteady gait"; and B. "2000 (8 PM) pt attempts to get out of bed, unsteady gait". The "Patient Care Notes" portion were recorded as: "2100 (9 PM), Patient is awake, alert with no distress noted. Denies any pain or discomfort. Patient with Posey vest on for safety." 5. The care plans were not updated to include the use of restraints. 6. There were no consent forms in the record, authorizing the use of restraints.	A 154		

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A 154	Continued From page 20 Patient #29 was admitted to the facility on 9/17/08 with diagnoses including Pleural Effusion; Cardiomyopathy; Edema; Atrial Fibrillation; and Hypoxemia 1. Restraint orders: - 9/25/08; time 0800 (8:00AM); duration 24 hr; type: B (bilateral) soft wrist restraints; reason: pulling out tubes. - 9/25/08; time 0900 (9:00AM); duration 24 hr; type: wrist restraints; reason: pulls out PICC (peripherally inserted central catheter) line, risk for fall. 2. The "Restraints" portion of the 9/24/08 "Patient Care Record" indicated staff initialed off at three 2 hour intervals (0200 - 2 AM; 0400 - 4 AM; and 0600 - 6 AM). There were 3 unreadable entries. 3. The forms specified in the policy (Titled: Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12) were not in the patient's record. The forms were the Physical Restraint Assessment, Physical Restraint Follow-Up, Restraint Chart Checklist, Informed Consent Restraint Use, Interdisciplinary Care Plan Physical Restraint, and the Restraint Tracking/Trending Log. 4. The record contained no documented evidence less restrictive measures and alternatives were tried. 5. The record contained no documented evidence reassessment to terminate the restraints was completed during the 2 hour removal and repositioning period.	A 154		

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A 154	Continued From page 21 6. On 9/25/08 at 4:30 PM, there were no care plans in the patient's record. Employee #22 and an unidentified employee confirmed there was no care plan available for Patient #29. 7. There were no consent forms in the record, authorizing the use of restraints. On 9/25/08 at 10:00AM, an interview with Patient #29's daughter and wife indicated they had not been notified Patient #29 was in wrist restraints. The daughter reported they were informed of the restraint use when they came in to visit at 8 AM. The daughter reported the staff told her the patient went into the restraints at approximately midnight and it was because the patient was pulling out his tubes. Patient #30 was admitted to the facility on 9/11/08 with diagnoses including Food/Vomit Pneumonitis; Hypertension; Dysphagia;Other Mental disorder; and Obstructive Chronic Bronchitis. 1. Restraint Orders: - 9/19/08; time 1800 (6 PM); duration: 24 hour; type: wrist restraints; reason: pulls out oxygen nasal. - 9/20/08; time 1800 (6 PM); duration: 24 hour; type: wrist restraints; reason: pulls out NGT (nasogastric feeding tube). - 9/21/08; time 1800 (6 PM); duration: 24 hour; type: wrist restraints; reason: pulls out NGT (nasogastric feeding tube). - 9/25/08; time 0800 (8 am); duration: 24 hour; type: wrist restraints; reason: pulls out NGT (nasogastric feeding tube).	A 154		

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A 154	Continued From page 22 2. The "Restraints" portion of the 9/19/08 "Patient Care Record" indicated staff initialed off 24 hours of 2 hour intervals (0800 - AM through 0600 - AM). The written entries included: A. "Patient bilateral wrist restraints released every 2 hours and when family member supervises the patient for circulation, hydration, redness noted, all pulses of upper extremities present; and B. six entries were all recorded as "Checked circulation." The "Patient Care Notes" portion recorded: A. 1430 (2:30 PM) "..checked for circulation in bilateral restraints, all pulses present." 3. The "Restraints" portion of the 9/21/08 "Patient Care Record" indicated staff initialed off 24 hours of 2 hour intervals (0800 - 8 AM through 0600 - AM). There were 2 written entries: A. "Patient bilateral wrist restraints removed every 2 hours or when family member supervises the patient. Restraints removed for circulation all pulse present, no redness or edema noted. Patient given ice chips, oral done frequently"; and B. "Bilateral wrist restraints on patient pulled ng tube. Checked restraints q (every) 2 hours released at times for circulation." The "Patient Care Notes" portion recorded: A. 1200 (noon) "...patient calm resting on the bed, Bilateral wrist restraints removed, patient wife monitors the patient"; B. "1400 (2 PM) patient calm resting in bed wife supervises bilateral wrist restraints off..." 4. The "Restraints" portion of the 9/23/08 "Patient Care Record" indicated staff initialed off at six 2 hour intervals (0800 - 8 AM; 1000 - 10 AM; 1200 (noon); 1400 (2 PM); 1600 (4 PM); and 1800 - 6	A 154		

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A 154	Continued From page 23 PM. There was 1 written entry: "Both wrist restraints." The "Patient Care Notes" portion recorded: -1900 (7 PM); "Placed on both wrist restraints..." - 20 (8 PM); "...Patient on bilateral soft wrist restraints on." 5. The forms specified in the policy (Titled: Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12) were not in the patient's record. The forms were the Physical Restraint Assessment, Physical Restraint Follow-Up, Restraint Chart Checklist, Informed Consent Restraint Use, Interdisciplinary Care Plan Physical Restraint, and the Restraint Tracking/Trending Log. 6. The record contained no documented evidence less restrictive measures and alternatives were tried. 7. There were no consent forms in the record, authorizing the use of restraints. The facility presented five different policies on the use of restraint. The hospital did not have accreditation by an accrediting body approved by the Centers for Medicare and Medicaid Services. 1. The facility policy titled "Restraints" (undated policy), documented on page 4 of the policy that the references used to develop the policy was the Medicare Hospital Conditions of Participation: Patient Rights; and the JCAHO (Joint Commission Accreditation): 2004 Patient Care Standards.	A 154		

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A 154	Continued From page 24 The policy documented the following: - on page 1, item 3 - "The use of the least restrictive method that meets the patient needs will be applied only after alternative methods have been attempted and failed to meet patient needs (see Attachment A - A listed examples of alternatives i.e. diversion activities, communication skills, environment). Alternative measures must be documented. - on page 2, item 4 - "...alternatives must be documented..." - on page 2, item 9 - "The restraint order will be in accordance with an immediate written modification to the care plan, i.e., it will be used only in an exception, in response to a plan of care (POC) that was modified after the use of normal care procedures failed." - on page 3 item 5b - "Pink Physical Restraint Order Sticker is placed on the physician's order sheet..." - on page 3, item 5c - "Reason for the restraint, ...For Safety is not acceptable." - on page 3, item 6b - "...The patient's care plan will reflect increased monitoring from 2 hour intervals to 1 hour intervals, as medically indicated..." - on page 4, item 10 - "Monitoring and reassessment may permit the reduction or early termination of restraint. Staff may release restraint before the time limit, based on assessment. The original order can be reapplied, within the 24 hour time frames of the original order if alternatives are ineffective, when restraint is terminated early and the same behavior is evident." - on page 4, item 11 - "..POC addresses restraint use and documentation of ongoing monitoring and care. Care plans are to be updated only after	A 154		

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restraint alternatives have been tried and found to be ineffective. Care plans are updated as soon as possible after the restraint has been determined appropriate and necessary. The care plan will address the frequency and monitoring..."
- on page 8, item 8 - "the possible use of restraint is discussed with the patient and/or family whenever possible and include behaviors requiring the need for restraint and what behavioral condition resulting in restraint removal and the patient's understanding of the same."

2. The facility policy titled "Nursing Services, 309km, Restraint Procedure, 4 pages dated 7/93 with the most current revision dated 12/06, approval signatures were dated 1/2/07 and 1/8/07" documented the following:

- page 2 item policy 3 - "The use of the least restrictive method that meets the patient needs will be applied only after alternative methods have been attempted and failed to meet patient needs (see Attachment A - A listed examples of alternatives i.e. diversion activities, communication skills, environment). Alternative measures must be documented."
- page 2 item policy 4 - "Initial assessment, continuous, and alternatives must be documented..."
- page 2 item 5a - "an RN (Registered Nurse) must assess the patient daily to determine the need..."
- page 2 item 5b - "Pink Physical Restraint Order Sticker is placed on the physician's order sheet..."
- page 2 item 5e - "Reason for the restraint...For Safety is not acceptable."
- page 3, item 8 - "the possible use of restraint is discussed with the patient and/or family whenever possible and include behaviors requiring the need

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for restraint and what behavioral condition resulting in restraint removal and the patient's understanding of the same."
- page 3, item 11 - "..Plan of Care addresses restraint use and documentation of ongoing monitoring and care. Care plans are to be updated only after restraint alternatives have been tried and found to be ineffective. Care plans are updated as soon as possible after the restraint has been determined appropriate and necessary."

3. The facility policy titled "Nursing Services, 309gf, Restraint Procedure, 5 pages dated 7/93 with the most current revision dated 12/03, no approval signatures were on the procedure" documented the following:

- The items mirrored the later approved version "Nursing Services, 309km, Restraint Procedure".

4. The facility policy titled "Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12" documented the following:

- Page R-5, item policy 1 - "...restraints will not be used unless the facility's Interdisciplinary Team (IDT) has completed an assessment and evaluation to identify causative medical or environmental factors and considered less restrictive alternatives (except in an emergency). Emergency is defined as when a patient's behavior threatens his own health or safety..."

- There was 1 set of procedures identified as follows:

- Page R-5, item procedures 1 - "...with a restraint order and/or as condition necessitates,

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A 154	Continued From page 27 the nurse completes a restraint assessment, establishes a plan, obtains an order, consent and updates the care plan prior to implementing the plan." - Page R-5, item procedures 2 - "The IDT meets as soon as possible to review the assessment, and consider if all alternatives and interventions have been selected and implemented...maintain the highest level of functioning with the least restrictive measures." - Page R-6, item 4 - "All alternatives attempted prior to consideration of using restraint are documented in the patient's medical record." - Page R-6, item 6 - "the facility is responsible for obtaining informed consent from the patient, family...if the patient lacks medical decision making." - Page R-6, item 7 - "Enter the problem, goal and approaches in the patient's care plan. The approaches must include frequent observation, release, and reposition..." - Page R-6, item 8 - "Documentation of restraint effectiveness is maintained in the medical record." - Page R-6, item 9 - " Medical symptoms that warrant the use of restraints are reflected in the comprehensive assessment and care planning." - Page R-6, item 10 - "It is further expected...care plans indicate the need for restraints the facility engages in a systematic and gradual process towards reducing restraints." - Page R-7-12 were the sample forms to be used: Physical Restraint Assessment; Follow-up; Chart Checklist; Informed Consent; Care Plan - Physical Restraint; and Tracking and Trending Log. 5. The facility policy titled "What You Need to Know, Untying the Mysteries of Restraints";	A 154		

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A 154	Continued From page 28 Section III Nursing Policies and Procedures, Restraint, original: 3/2006, Revision 3/2008; pages 4-5." - The items mirrored the later approved version "Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5". 6. The instructions of the "Restraints" portion of the "Daily Patient Care Record" read: "Initial in the timed box the patient was checked for circulation/skin condition under the restraint and patient need for hydration, nutrition, exercise and toileting. Indicate if restraint on/off." 7. On 9/25/08 in the afternoon, the Acting DON (Director of Nursing) reported the policies provided were the policies utilized by the facility. 8. On 9/26/08 in the morning, the Staff Developer presented another Nursing Policies and Procedures on Restraints (refer to item #4 in policy review) and indicated this restraint policy was what corporate wanted the facility to utilize. The Staff Developer reported she just began (first training session 9/9/08 and the second 9/17/08) training the staff. 9. Interviews with Charge Nurses (RN) and Floor Nurses from each of the 6 units were conducted on 9/25/08 beginning at 10:30 AM. The interviews revealed: - the staff had an idea of restraint use, but were not necessarily trained at the facility, an LPN (Licensed Practical Nurse) could not recall if she was trained by the facility, other staff remembered doing training on the computer, one staff reported competencies were completed yearly. A	A 154		

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A 154	Continued From page 29 Registered Nurse (RN) reported she was not trained however she could go to her supervisor. - the staff were unsure of what the facility policy was and were unaware of where it was located. - the staff were unsure of where to obtain restraints and what to do with the restraints when they were removed. Some staff thought restraints were kept in the supply room, others said restraints were kept in the laundry, another unit presented restraints that were kept on a cart on the unit. One RN stated she would throw away the wrist restraints and Posey vests after use. - the staff were unsure if they were to inform the family, some staff stated they would call the family unless it was night. - not all staff were aware of where to document restraint use. Most of the RNs reported they would document on the daily nursing notes. No one mentioned updating the Care Plan. - Only 1 RN mentioned least restrictive and alternative measures prior to restraint application.	A 154		
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on interview, document review and record review the facility failed to ensure less restrictive interventions were determined to be ineffective for 4 of 36 patients (#1, #28, #29, #30).	A 164		

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A 164	Continued From page 30 Findings include: Patient #1 was admitted to the facility on 12/28/07 and discharged on 1/16/08 with diagnoses including Pneumonia; Hypertension; Debility; and Other Mental Condition 1. Restraint Orders - 12/29/07; time 10:05; duration 24 hour; type Vest; reason: trying to get out of bed/hx (history) of fall. - 12/31/07; time 0700 (7:00AM); duration 24 hour (hr); type PV (Posey vest); reason: climbs out of bed no safety awareness. - 12/30/07; time 0700; duration 24 hr; type Posey vest; reason: climbs out of bed no safety awareness. - 1/07/08; time 0700; duration 24 hr; type PV; reason: climbs out of bed no safety awareness. - 1/8/08; time 0700; duration 24 hr; type PV; reason: climbs out of bed no safety awareness - 1/12/08; time 0800 (8:00AM); duration 24 hr; type Posey vest; reason: attempts to get out of bed without assistance, fall precautions. - 1/16/08; time 0800; duration 24 hr; type PV; reason: attempts to get out of bed without assistance, fall precautions. 2. The forms specified in the policy (Titled: Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12) were not in the patient's record. The forms included Physical Restraint Assessment, Physical Restraint Follow-Up, Restraint Chart Checklist, Informed Consent Restraint Use, Interdisciplinary Care Plan Physical Restraint, and Restraint Tracking/Trending Log.	A 164		

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A 164	Continued From page 31 3. The record contained no documented evidence less restrictive measures and alternatives were tried. 4. The record contained no documented evidence a reassessment to terminate the restraints was done during the 2 hour removal and repositioning period. 5. The care plans were not updated to include the use of restraints. Patient #28 was admitted to the facility on 9/17/08 with diagnoses including Altered Mental State; Depressive Disorder; Hypertension; Anxiety State; Other Chronic Pain; Pneumonia, Hypertension; Debility; and Other Mental Condition 1. Physician's Orders: An order was written on 9/23/08 at 0800, "Posey Vest for pts' (patient's) safety." There was no pink physical restraint sticker as specified in the policies and procedures listed below: - "...The Pink Physical Restraint Order Sticker is placed on the physician's order sheet..." - "..."For Safety" is not an acceptable rational for restraint use..." - "...There was no specifications of duration...." 2. The forms specified in the policy (Titled: Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12) were not in the patient's record. The forms included Physical Restraint Assessment, Physical Restraint Follow-Up, Restraint Chart Checklist,	A 164		

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A 164	Continued From page 32 Informed Consent Restraint Use, Interdisciplinary Care Plan Physical Restraint, and Restraint Tracking/Trending Log. 3. The record contained no documented evidence less restrictive measures and alternatives were tried. 4. The record contained no documented evidence a reassessment to terminate the restraints was done during the 2 hour removal and repositioning period at: 0800 (AM); 1000 (10 AM); 1200 (noon); 1400 (2 PM); 1600 (4 PM); 1800 (6 PM); 2000 (8 PM); and 2200 (10 PM). The "Restraints" portion of the 9/24/08 "Patient Care Record" indicated staff initialed off at eight 2 hour intervals. There were only 2 entries made in this section: A. "Pt (patient) attempts to get out of bed, unsteady gait"; and B. 2000 (8 PM) "pt attempts to get out of bed, unsteady gait". The "Patient Care Notes" portion were recorded as: 2100 (9 PM), "Patient is awake, alert with no distress noted. Denies any pain or discomfort. Patient with Posey vest on for safety." 5. The care plans were not updated to include the use of restraints. Patient #29 was admitted to the facility on 9/17/08 with diagnoses including Pleural Effusion; Cardiomyopathy; Edema; Atrial Fibrillation; and Hypoxemia 1. Restraint orders:	A 164		

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A 164	Continued From page 33 - 9/25/08; time 0800 (8:00AM); duration 24 hr; type: B (bilateral) soft wrist restraints; reason: pulling out tubes. - 9/25/08; time 0900 (9:00AM); duration 24 hr; type: wrist restraints; reason: pulls out PICC (peripherally inserted central catheter) line, risk for fall. 2. The "Restraints" portion of the 9/24/08 "Patient Care Record" indicated staff initialed off at three 2 hour intervals (0200 - 2 AM; 0400 - 4 AM; and 0600 - 6 AM). There were 3 unreadable entries. 3. The forms specified in the policy (Titled: Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12) were not in the patient's record. The forms included Physical Restraint Assessment, Physical Restraint Follow-Up, Restraint Chart Checklist, Informed Consent Restraint Use, Interdisciplinary Care Plan Physical Restraint, and Restraint Tracking/Trending Log. 4. The record contained no documented evidence less restrictive measures and alternatives were tried. 5. The record contained no documented evidence that reassessment to terminate the restraints was done during the 2 hour removal and repositioning period. 6. On 9/25/08 at 4:30PM, there were no care plans in the patient's record. Employee #22 and an unidentified employee confirmed there was no care available for patient Patient #28. 7. On 9/25/08 at 10:00AM, an interview with Patient #29's daughter and wife revealed they had	A 164		

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A 164	Continued From page 34 not been notified #29 was in wrist restraints. The daughter reported they were informed when they came in to visit at 8 AM. The daughter reported the staff told her the patient went into the restraints at approximately midnight and it was because the patient was pulling out his tubes. The daughter indicated the staff did not express less restrictive alternatives were attempted before the patient was put into restraints. Patient #30 was admitted to the facility on 9/11/08 with diagnoses including Food/Vomit Pneumonitis; Hypertension; Dysphagia;Other Mental disorder; and Obstructive Chronic Bronchitis. 1. Restraint Orders: - 9/19/08; time 1800 (6 PM); duration: 24 hour; type: wrist restraints; reason: pulls out oxygen nasal. - 9/20/08; time 1800 (6 PM); duration: 24 hour; type: wrist restraints; reason: pulls out NGT (nasogastric feeding tube). - 9/21/08; time 1800 (6 PM); duration: 24 hour; type: wrist restraints; reason: pulls out NGT (nasogastric feeding tube). - 9/25/08; time 0800 (8 am); duration: 24 hour; type: wrist restraints; reason: pulls out NGT (nasogastric feeding tube). 2. The "Restraints" portion of the 9/19/08 "Patient Care Record" indicated staff initialed off 24 hours of 2 hour intervals (0800 - AM through 0600 - AM). The written entries included: A. "Patient bilateral wrist restraints released every 2 hours and when family member supervises the patient for circulation, hydration, redness noted, all pulses of upper extremities present.; B. six entries were all recorded as "Checked	A 164		

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A 164	Continued From page 35 circulation." The "Patient Care Notes" portion recorded: A. 1430 (2:30 PM) "...checked for circulation in bilateral restraints, all pulses present." 3. The "Restraints" portion of the 9/21/08 "Patient Care Record" indicated staff initialed off 24 hours of 2 hour intervals (0800 - 8 AM through 0600 - AM). There were 2 written entries: A. "Patient bilateral wrist restraints removed every 2 hours or when family member supervises the patient. Restraints removed for circulation all pulse present, no redness or edema noted. Patient given ice chips, oral done frequently" and B. "Bilateral wrist restraints on patient pulled ng (nasogastric) tube. Checked restraints q (every) 2 hours released at times for circulation." The "Patient Care Notes" portion recorded: A. 1200 (noon) "...patient calm resting on the bed, Bilateral wrist restraints removed, patient wife monitors the patient." B. 1400 (2 PM) "patient calm resting in bed wife supervises bilateral wrist restraints off..." 4. The "Restraints" portion of the 9/23/08 "Patient Care Record" indicated staff initialed off at six 2 hour intervals 0800 (8 AM); 1000 (10 AM); 1200 (noon); 1400 (2 PM); 1600 (4 PM); and 1800 - (6 PM). There was 1 written entry: "Both wrist restraints." The "Patient Care Notes" portion recorded: -1900 (7 PM); "Placed on both wrist restraints..." - 20 (8 PM); "...Patient on bilateral soft wrist restraints on." 5. The forms specified in the policy (Titled:	A 164		

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A 164	Continued From page 36 Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12) were not in the patient's record. The forms included Physical Restraint Assessment, Physical Restraint Follow-Up, Restraint Chart Checklist, Informed Consent Restraint Use, Interdisciplinary Care Plan Physical Restraint, and Restraint Tracking/Trending Log. 6. The record contained no documented evidence less restrictive measures and alternatives were tried. The facility presented five different policies on the use of restraint. 1. The facility policy titled Restraints (undated policy), documented on page 4 was "References: Medicare Hospital Conditions of Participation: Patient Rights; JCAHO (Joint Commission Accreditation): 2004 Patient Care Standards." - on page 1, item 3 - "The use of the least restrictive method that meets the patient needs will be applied only after alternative methods have been attempted and failed to meet patient needs (see Attachment A - A listed examples of alternatives i.e. diversion activities, communication skills, environment). Alternative measures must be documented..." - on page 2, item 4 - "....alternatives must be documented..." - on page 2, item 9 - "The restraint order will be in accordance with an immediate written modification to the care plan, i.e., it will be used only in an exception, in response to a plan of care (POC) that was modified after the use of normal care procedures failed." - page 4, item 10 - "Monitoring and reassessment may permit the reduction or early	A 164		

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A 164	Continued From page 37 termination of restraint. Staff may release restraint before the time limit, based on assessment. The original order can be reapplied, within the 24 hour time frames of the original order if alternatives are ineffective, when restraint is terminated early and the same behavior is evident." - page 4, item 11 - "..POC (plan of care) addresses restraint use and documentation of ongoing monitoring and care. Care plans are to be updated only after restraint alternatives have been tried and found to be ineffective. Care plans are updated as soon as possible after the restraint has been determined appropriate and necessary. The care plan will address the frequency and monitoring. - on page 8, item 8 - "the possible use of restraint is discussed with the patient and/or family whenever possible and include behaviors requiring the need for restraint and what behavioral condition resulting in restraint removal and the patient's understanding of the same." 2. The facility policy titled "Nursing Services, 309km, Restraint Procedure, 4 pages dated 7/93 with the most current revision dated 12/06, approval signatures were dated 1/2/07 and 1/8/07" documented the following: - on page 2 item policy 3 - "The use of the least restrictive method that meets the patient needs will be applied only after alternative methods have been attempted and failed to meet patient needs (see Attachment A - A listed examples of alternatives i.e. diversion activities, communication skills, environment). Alternative measures must be documented." - on page 2 item policy 4 - "Initial assessment, continuous, and alternatives must be documented..."	A 164		

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A 164	Continued From page 38 - on page 2 item 5a - "an RN (Registered Nurse) must assess the patient daily to determine the need..." - on page 3, item 8 - "the possible use of restraint is discussed with the patient and/or family whenever possible and include behaviors requiring the need for restraint and what behavioral condition resulting in restraint removal and the patient's understanding of the same." - on page 3, item 11 - "..Plan of Care addresses restraint use and documentation of ongoing monitoring and care. Care plans are to be updated only after restraint alternatives have been tried and found to be ineffective. Care plans are updated as soon as possible after the restraint has been determined appropriate and necessary." 3. The facility policy titled "Nursing Services, 309gf, Restraint Procedure, 5 pages dated 7/93 with the most current revision dated 12/03, no approval signatures were on the procedure." - The items mirrored the later approved version "Nursing Services, 309km, Restraint Procedure, 4 pages dated 7/93 with the most current revision dated 12/06, approval signatures were dated 1/2/07 and 1/8/07". 4. The facility policy titled "Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12" documented the following: - on page R-5, item policy 1 - "...restraints will not be used unless the facility's Interdisciplinary Team (IDT) has completed an assessment and evaluation to identify causative medical or environmental factors and considered less restrictive alternatives (except in an emergency). Emergency is defined as when a patient's	A 164		

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A 164	Continued From page 39 behavior threatens his own health or safety ...." - There was 1 set of procedures identified as follows: - on page R-5, item procedures 1 - "...with a restraint order and/or as condition necessitates, the nurse completes a restraint assessment, establishes a plan, obtains an order, consent and updates the care plan prior to implementing the plan." - on page R-5, item procedures 2 - "The IDT meets as soon as possible to review the assessment, and consider if all alternatives and interventions have been selected and implemented .....maintain the highest level of functioning with the least restrictive measures." - on page R-6, item 4 - "All alternatives attempted prior to consideration of using restrain are documented in the patient's medical record." - on page R-6, item 8 - "Documentation of restraint effectiveness is maintained in the medical record." - on page R-6, item 9 - " Medical symptoms that warrant the use of restraints are reflected in the comprehensive assessment and care planning." - on page R-6, item 10 - "It is further expected...care plans indicate the need for restraints the facility engages in a systematic and gradual process towards reducing restraints." - on page R-7-12 are the sample forms to be used for: Physical Restraint Assessment; Follow-up; Chart Checklist; Informed Consent; Care Plan - Physical Restraint; and Tracking and Trending Log. 5. The facility policy titled "What You Need to Know, Untying the Mysteries of Restraints"; Section III Nursing Policies and Procedures,	A 164		

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A 164	Continued From page 40 Restraint, original: 3/2006, Revision 3/2008; pages 4-5. - The items mirrored the later approved version "Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12" . 6. The instructions of the "Restraints" portion of the "Daily Patient Care Record" read: "Initial in the timed box the patient was checked for circulation/skin condition under the restraint and patient need for hydration, nutrition, exercise and toileting. Indicate if restraint on/off." 7. On 9/25/08 in the afternoon , the Acting DON (Director of Nursing) reported the policies provided were the policies utilized by the facility. 8. On 9/26/08 in the morning , the Staff Developer presented another Nursing Policies and Procedures on Restraints (refer to item #4 in policy review) and indicated this restraint policy was what corporate wanted the facility to utilize. The Staff Developer reported she just began (first training session 9/9/08 and the second 9/17/08) training the staff. 9. Interviews with Charge Nurses (RN) and Floor Nurses from each of the 6 units were conducted on 9/25/08 beginning at 10:30 AM. The interviews revealed: - The staff had an idea of restraint use, but were not necessarily trained at the facility, an LPN (Licensed Practical Nurse) could not recall if she was trained by the facility, other staff remembered doing training on the computer, one staff reported competencies were completed yearly. A Registered Nurse (RN) reported she was not	A 164		

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	290042	A. BUILDING _____ B. WING _____	09/26/2008

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A 164	Continued From page 41 trained however she could go to her supervisor. - The staff were unsure of what the facility policy was and were unaware of where it was located. - The staff were unsure of where to obtain restraints and what to do with them after they were removed. Some staff thought restraints were kept in the supply room, others said restraints were kept in the laundry, another hall presented restraints that were kept on a cart on the unit. One RN stated she would throw away the wrist restraints and Posey vests after use. - The staff were unsure if they were to inform the family, some staff stated they would call the family unless it was night. - Not all staff were aware of where to document restraint use. Most of the RNs reported they would document on the daily nursing notes. No one mentioned updating the Care Plan. - One RN mentioned least restrictive and alternative measures prior to restraint application.	A 164		
A 165	482.13(e)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient or others from harm. This STANDARD is not met as evidenced by: Based on interview, document review and record review the facility failed to ensure the type of restraint used must be the most effective, least restrictive intervention for 4 of 36 patients (#1, #28, #29, #30).	A 165		

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A 165	Continued From page 42 Findings include: 1. Patient #1 was admitted to the facility on 12/28/07 and discharged on 1/16/08 with diagnoses including Pneumonia; Hypertension; Debility; and Other Mental Condition The patient had physican orders from 12/29/07 - 1/16/08, for a posey vest retraint due to the patient was trying to get out of bed without assistance, a history of falling, and no safety awareness. A review of Patient #1's record revealed there was no documented evidence less restrictive measures and alternatives were tried before the patient was placed in restraints. 2. Patient #28 was admitted to the facility on 9/17/08 with diagnoses including Altered Mental State; Depressive Disorder; Hypertension; Anxiety State; Other Chronic Pain; Pneumonia, Hypertension; Debility; and Other Mental Condition. The patient had a physician order dated 9/23/08, for a posey vest for safety. The record contained no documented evidence less restrictive measures and alternatives were tried. 3. Patient #29 was admitted to the facility on 9/17/08 with diagnoses including Pleural Effusion; Cardiomyopathy; Edema; Atrial Fibrillation; and Hypoxemia. A review of the record revealed the patient had a	A 165		

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A 165	Continued From page 43 physician order for bilateral soft wrist restraints on 9/25/08 due to the patient was pulling out tubes. The record documented the patient was pulling out the peripherally inserted central catheter (PICC) and was a risk for falls. The record contained no documented evidence less restrictive measures and alternatives were tried. The record contained no documented evidence a reassessment to terminate the necessity or the least restrictive restraint was completed during the removal and repositioning period. 4. Patient #30 was admitted to the facility on 9/11/08 with diagnoses including Food/Vomit Pneumonitis; Hypertension; Dysphagia;Other Mental disorder; and Obstructive Chronic Bronchitis. A review of the records revealed the patient had a physician order from 9/19/08 - 9/25/08 for wrist retraints due to pulling out the nasal oxygen tubing and the nasogastric feeding tube. The record contained no documented evidence less restrictive measures and alternatives were tried. The facility presented five different policies on the use of restraint. 1. The facility policy titled "Restraints (undated) documented the following: - on page 1, item 3 - "The use of the least restrictive method that meets the patient needs will be applied only after alternative methods have been attempted and failed to meet patient needs	A 165		

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A 165	Continued From page 44 (see Attachment A - A listed examples of alternatives i.e. diversion activities, communication skills, environment). Alternative measures must be documented. - on page 2, item 4 - "....alternatives must be documented..." - on page 4, item 10 - "Monitoring and reassessment may permit the reduction or early termination of restraint. Staff may release restraint before the time limit, based on assessment. The original order can be reapplied, within the 24 hour time frames of the original order if alternatives are ineffective, when restraint is terminated early and the same behavior is evident." - on page 4, item 11 - "..Plan of Care addresses restraint use and documentation of ongoing monitoring and care. Care plans are to be updated only after restraint alternatives have been tried and found to be ineffective. Care plans are updated as soon as possible after the restraint has been determined appropriate and necessary. The care plan will address the frequency and monitoring." 2. The facility policy titled "Nursing Services, 309km, Restraint Procedure, 4 pages dated 7/93 with the most current revision dated 12/06, approval signatures were dated 1/2/07 and 1/8/07" documented the following: - on page 2 item policy 3 - "The use of the least restrictive method that meets the patient needs will be applied only after alternative methods have been attempted and failed to meet patient needs (see Attachment A - A listed examples of alternatives i.e. diversion activities, communication skills, environment). Alternative measures must be documented." - on page 2 item policy 4 - "Initial assessment,	A 165		

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A 165	Continued From page 45 continuous, and alternatives must be documented..." - on page 2 item 5a - "an RN (registered nurse) must assess the patient daily to determine the need..." - on page 3, item 11 - "..Plan of Care addresses restraint use and documentation of ongoing monitoring and care. Care plans are to be updated only after restraint alternatives have been tried and found to be ineffective. Care plans are updated as soon as possible after the restraint has been determined appropriate and necessary." 3. The facility policy titled "Nursing Services, 309gf, Restraint Procedure, 5 pages dated 7/93 with the most current revision dated 12/03, no approval signatures were on the procedure" documented the same information as listed above. 4. The facility policy titled "Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12" documented the following - on page R-5, item policy 1 - "...restraints will not be used unless the facility's Interdisciplinary Team (IDT) has completed an assessment and evaluation to identify causative medical or environmental factors and considered less restrictive alternatives (except in an emergency). Emergency is defined as when a patient's behavior threatens his own health or safety ...." - There was 1 set of procedures identified as follows: - on page R-5, item procedures 1 - "...with a restraint order and/or as condition necessitates, the nurse completes a restraint assessment,	A 165		

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A 165	Continued From page 46 establishes a plan, obtains an order, consent and updates the care plan prior to implementing the plan". -on page R-5, item procedures 2 - "The IDT meets as soon as possible to review the assessment, and consider if all alternatives and interventions have been selected and implemented...maintain the highest level of functioning with the least restrictive measures." - on page R-6, item 4 - "All alternatives attempted prior to consideration of using restraint are documented in the patient's medical record." - on page R-6, item 7 - "Enter the problem, goal and approaches in the patient's care plan. The approaches must include frequent observation, release, and reposition..." - on page R-6, item 8 - "Documentation of restraint effectiveness is maintained in the medical record." - on page R-6, item 9 - " Medical symptoms that warrant the use of restraints are reflected in the comprehensive assessment and care planning." - on page R-6, item 10 - "It is further expected...care plans indicate the need for restraints the facility engages in a systematic and gradual process towards reducing restraints." 5. The facilit policy titled: "What You Need to Know, Untying the Mysteries of Restraints"; Section III Nursing Policies and Procedures, Restraint, original: 3/2006, Revision 3/2008; pages 4-5. - The items mirrored the later approved version (as listed above). 6. On 9/25/08 in the afternoon , the Acting DON (Director of Nursing) reported the policies provided were the policies utilized by the facility.	A 165		

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A 165	Continued From page 47 7. On 9/26/08 in the morning , the Staff Developer presented another Nursing Policies and Procedures on Restraints (refer to item #4 in policy review) and indicated this restraint policy was what corporate wanted the facility to utilize. The Staff Developer reported she just began (first training session 9/9/08 and the second 9/17/08) training the staff. 8. Interviews with Charge Nurses (RN) and Floor Nurses from each of the 6 units were interviewed on 9/25/08 beginning at 10:30 AM. The interviews revealed: - the staff had an idea of restraint use, but were not necessarily trained at the facility, an LPN (Licensed Practical Nurse) could not recall if she was trained by the facility, other staff remembered doing training on the computer, one staff reported competencies were completed yearly. A RN reported she was not trained however she could go to her supervisor. - the staff were unsure of what the facility policy was and were unaware of where it was kept. - the staff were unsure of where to obtain restraints and what to do with them after they were removed. Some staff thought restraints were kept in the supply room, others said restraints were kept in the laundry, another hall presented restraints that were kept on a cart on the unit. One RN stated she would throw away the wrist restraints and Posey vests after use. - not all staff were aware of where to document restraint use. Most of the RNs reported they would document on the daily nursing notes. No	A 165		

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A 165	Continued From page 48 one mentioned updating the Care Plan. - One RN mentioned least restrictive and alternative measures prior to restraint application.	A 165		
A 166	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on interview, document review and record review, the facility failed to ensure the use of restraint was in accordance with a written modification to the patient's plan of care for 4 of 36 patients (#1, #28, #29, #30). Findings Include: 1. Patient #1 was admitted to the facility on 12/28/07 and discharged on 1/16/08 with diagnoses including Pneumonia; Hypertension; Debility; and Other Mental Condition A review of the record indicated the patient had physician orders dated 12/29/07 - 1/16/08 for a Posey vest restraint due to trying to get out of bed without assistance, history of falls, and no safety awareness. The care plans were not updated to include the use of restraints. 2. Patient #28 was admitted to the facility on 9/17/08 with diagnoses including Altered Mental State; Depressive Disorder; Hypertension; Anxiety State; Other Chronic Pain; Pneumonia, Hypertension; Debility; and Other Mental	A 166		

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A 166	Continued From page 49 Condition A review of the record indicated the patient had a physician order dated 9/23/08 at 0800 for "Posey Vest for pts' (patient's) safety." The care plans were not updated to include the use of restraints. 3. Patient #29 was admitted to the facility on 9/17/08 with diagnoses including Pleural Effusion; Cardiomyopathy; Edema; Atrial Fibrillation; and Hypoxemia. A review of the record indicated the patient had physician orders dated 9/25/08 for bilateral soft wrist restrains due to the patient was pulling out tubes (peripherally inserted central catheter). On 9/25/08 at 4:30 PM, there were no care plans in the patient's record. Employee #22 and an unidentified employee confirmed there was no care available for patient #29. 4. Patient #30 was admitted to the facility on 9/11/08 with diagnoses including Food/Vomit Pneumonitis; Hypertension; Dysphagia;Other Mental disorder; and Obstructive Chronic Bronchitis. A review of the record indicated the patient had physician orders dated 9/19/08 - 9/25/08 for wrist restraints due to pulling out oxygen nasal tubing and nasogastric feeding tube. The care plans were not updated to include the use of restraints.	A 166		

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A 166	Continued From page 50 The facility presented five different policies on the use of restraint. 1. The facility policy titled "Restraints (undated), 6 pages, on page 4 was "References: Medicare Hospital Conditions of Participation: Patient Rights; JCAHO (Joint Commission Accreditation): 2004 Patient Care Standards." - on page 3, item 6b - "...The patient's care plan will reflect increased monitoring from 2 hour intervals to a hour intervals, as medically indicated..." - on page 4, item 11 - "..Plan of Care addresses restraint use and documentation of ongoing monitoring and care. Care plans are to be updated only after restraint alternatives have been tried and found to be ineffective. Care plans are updated as soon as possible after the restraint has been determined appropriate and necessary. The care plan will address the frequency and monitoring. - on page 8, item 8 - "the possible use of restraint is discussed with the patient and/or family whenever possible and include behaviors requiring the need for restraint and what behavioral condition resulting in restraint removal and the patient's understanding of the same." 2. The facility policy titled "Nursing Services, 309km, Restraint Procedure, 4 pages dated 7/93 with the most current revision dated 12/06, approval signatures were dated 1/2/07 and 1/8/07" documented the following: - on page 3, item 8 - "the possible use of restraint is discussed with the patient and/or family whenever possible and include behaviors requiring the need for restraint and what	A 166		

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A 166	Continued From page 51 behavioral condition resulting in restraint removal and the patient's understanding of the same." - on page 3, item 11 - "...Plan of Care addresses restraint use and documentation of ongoing monitoring and care. Care plans are to be updated only after restraint alternatives have been tried and found to be ineffective. Care plans are updated as soon as possible after the restraint has been determined appropriate and necessary." 3. The facility policy titled "Nursing Services, 309gf, Restraint Procedure, 5 pages dated 7/93 with the most current revision dated 12/03, no approval signatures were on the procedure." - The items mirrored the later approved version (as listed above). 4. The facility policy titled "Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12" documented the following: - on page R-5, item procedures 1 - "...with a restraint order and/or as condition necessitates, the nurse completes a restraint assessment, establishes a plan, obtains an order, consent and updates the care plan prior to implementing the plan". - on page R-5, item procedures 2 - "The IDT (interdisciplinary team) meets as soon as possible to review the assessment, and consider if all alternatives and interventions have been selected and implemented...maintain the highest level of functioning with the least restrictive measures." - on page R-6, item 7 - "Enter the problem, goal and approaches in the patient's care plan. The approaches must include frequent observation, release, and reposition..."	A 166		

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A 166	Continued From page 52 - on page R-6, item 9 - " Medical symptoms that warrant the use of restraints are reflected in the comprehensive assessment and care planning." - on page R-6, item 10 - "It is further expected...care plans indicate the need for restraints the facility engages in a systematic and gradual process towards reducing restraints." - on page R-7-12 were the sample forms to be used for: Physical Restraint Assessment; Follow-up; Chart Checklist; Informed Consent; Care Plan - Physical Restraint; and Tracking and Trending Log. 5. The facility policy titled: "What You Need to Know, Untying the Mysteries of Restraints"; Section III Nursing Policies and Procedures, Restraint, original: 3/2006, Revision 3/2008; pages 4-5. - The items mirrored the later approved version (as listed above). On 9/25/08 in the afternoon, the Acting DON (Director of Nursing) reported the policies provided were the policies utilized by the facility. On 9/26/08 in the morning, the Staff Developer presented another Nursing Policies and Procedures on Restraints (refer to item #4) and indicated this restraint policy was what corporate wanted the facility to utilize. The Staff Developer reported she just began (first training session 9/9/08 and the second 9/17/08) training the staff. Interviews with Charge Nurses (RN) and Floor Nurses from each of the 6 units were interviewed on 9/25/08 beginning at 10:30 AM. The interviews revealed:	A 166		

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A 166	Continued From page 53 - the staff had an idea of restraint use, but were not necessarily trained at the facility, an LPN (Licensed Practical Nurse) could not recall if she was trained by the facility, other staff remembered doing training on the computer, one staff reported competencies were completed yearly. A Registered Nurse reported she was not trained however she could go to her supervisor. - the staff were unsure of what the facility policy was and were unaware of where it was kept. - the staff were unsure of where to obtain restraints and what to do with them after they were removed. Some staff thought restraints were kept in the supply room, others said restraints were kept in the laundry, another hall presented restraints that were kept on a cart on the unit. One RN stated she would throw away the wrist restraints and Posey vests after use. - the staff were unsure if they were to inform the family, some staff stated they would call the family unless it was night. - not all staff were aware of where to document restraint use. Most of the RNs reported they would document on the daily nursing notes. No one mentioned updating the Care Plan. - One RN mentioned least restrictive and alternative measures prior to restraint application.	A 166		
A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). This STANDARD is not met as evidenced by:	A 169		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 169	Continued From page 54 Based on interview, document review and record review, the facility failed to ensure a written order was obtained for each use of restraint for 2 of 36 patients (#1, #28). Findings Include: 1. Patient #1 was admitted to the facility on 12/28/07 and discharged on 1/16/08 with diagnoses including Pneumonia; Hypertension; Debility; and Other Mental Condition Restraint Orders - 12/29/07; time 10:05AM; duration 24 hour; type Vest; reason: trying to get out of bed/hx (history) of fall. - 12/30/07; time 0700 (7:00AM); duration 24 hr; type Posey vest; reason: climbs out of bed no safety awareness. - 12/29/07: The same order was used to reapply restraints. The 10:00 AM and 12:00 PM notes stated "released and repositioned", the 2:00 PM and 4:00 PM note stated "off during family visit", the 6:00 PM note stated "released and repositioned." A new order was not obtained after the restraint was released and later reapplied within the same 24 hour period. A new order was required, the re-start of the same order constitutes a PRN (as needed) within that 24 hour period. 2. Patient #28 was admitted to the facility on 9/17/08 with diagnoses including Altered Mental State; Depressive Disorder; Hypertension; Anxiety State; Other Chronic Pain; Pneumonia, Hypertension; Debility; and Other Mental Condition	A 169		

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A 169	Continued From page 55 An order was written on 9/23/08 at 0800 (8:00 AM), "Posey Vest for pts' (patient's) safety." - The physician's order did not contain the specified duration of restraint use. The "Restraints" portion of the 9/24/08 "Patient Care Record" indicated staff initialed off at eight 2 hour intervals. There were only 2 entries made in this section: A. "Pt (patient) attempts to get out of bed, unsteady gait", and B. 2000 (8 PM) "pt attempts to get out of bed, unsteady gait". The "Patient Care Notes" portion (9/24/08) were recorded as: 2100 (9 PM), "Patient is awake, alert with no distress noted. Denies any pain or discomfort. Patient with Posey vest on for safety." The facility presented five different policies on the use of restraint. The following policies and procedures were in conflict with the "can not use as PRN (as needed)". Discontinuation of a restraint and then re-starting it under the same order constitutes a PRN order. 3. The facility policy titled Restraints (undated), 6 pages, on page 4 was "References: Medicare Hospital Conditions of Participation: Patient Rights; JCAHO (Joint Commission Accreditation): 2004 Patient Care Standards." - on page 4, item 10 - "Monitoring and reassessment may permit the reduction or early termination of restraint. Staff may release	A 169		

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A 169	Continued From page 56 restraint before the time limit, based on assessment. The original order can be reapplied, within the 24 hour time frames of the original order if alternatives are ineffective, when restraint is terminated early and the same behavior is evident." 4. The facility policy titled "Nursing Services, 309km, Restraint Procedure, 4 pages dated 7/93 with the most current revision dated 12/06, approval signatures were dated 1/2/07 and 1/8/07" documented the following: - on page 3, item 10 - "Monitoring and reassessment may permit the reduction or early termination of restraint. Staff may release restraint before the time limit, based on assessment. The original order can be reapplied, within the 24 hour time frames of the original order if alternatives are ineffective, when restraint is terminated early and the same behavior is evident." 5. The facility policy titled "Nursing Services, 309gf, Restraint Procedure, 5 pages dated 7/93 with the most current revision dated 12/03, no approval signatures were on the procedure". - The items mirrored the later approved version (as listed above). 6. On 9/25/08 in the afternoon, the Acting DON (Director of Nursing) reported the policies provided were the policies utilized by the facility.	A 169		
A 186	482.13(e)(16)(iii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of]	A 186		

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A 186	Continued From page 57 Alternatives or other less restrictive interventions attempted (as applicable); This STANDARD is not met as evidenced by: Based on interview, record review, and document review, the facility failed to ensure alternatives of less restrictive interventions were attempted for 4 of 36 patients (#1, #28, #29, #30). Findings Include: 1. Patient #1 was admitted to the facility on 12/28/07 and discharged on 1/16/08 with diagnoses including Pneumonia; Hypertension; Debility; and Other Mental Condition. A review of the record indicated the patient had physician orders dated 12/29/07 - 1/16/08 for a Posey vest restraint due to trying to get out of bed without assistance, history of falls, and no safety awareness. The forms specified in the policy (Titled: Nursing Policies and Procedures, Restraint, original: 3/2006; NP - R - 5 through 12) were not in the patient's record. The record contained no documented evidence less restrictive measures and alternatives were tried. 2. Patient #28 was admitted to the facility on 9/17/08 with diagnoses including Altered Mental State; Depressive Disorder; Hypertension; Anxiety State; Other Chronic Pain; Pneumonia, Hypertension; Debility; and Other Mental Condition.	A 186		

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A 186	Continued From page 58 A review of the record indicated an order was written on 9/23/08 at 0800 (8:00AM), "Posey Vest for pts' (patient's) safety." The record contained no documented evidence less restrictive measures and alternatives were tried. 3. Patient #29 was admitted to the facility on 9/17/08 with diagnoses including Pleural Effusion; Cardiomyopathy; Edema; Atrial Fibrillation; and Hypoxemia A review of the record indicated physician orders dated 9/25/08 at 0800 (8:00AM) and 0900 (9:00AM) for bilateral soft wrist restraints due to pulling out tubes (peripherally inserted central catheter) and a risk for falls. The record contained no documented evidence less restrictive measures and alternatives were tried. The record contained no documented evidence that a reassessment to terminate the restraints was done during the 2 hour removal and repositioning period. On 9/25/08 at 10 AM, an interview with Patient #29's daughter and wife revealed they had not been notified Patient #29 was in wrist restraints. The daughter reported they were informed when they came in to visit (8 AM). The daughter reported the staff told her the patient went into the restraints at approximately midnight and it was because the patient was pulling out his tubes. The daughter indicated the staff did not report any less restrictive measures were attempted.	A 186		

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A 186	Continued From page 59 4. Patient #30 was admitted to the facility on 9/11/08 with diagnoses including Food/Vomit Pneumonitis; Hypertension; Dysphagia;Other Mental disorder; and Obstructive Chronic Bronchitis. A review of the record indicated physician orders dated 9/19/08 - 9/25/08 for wrist restraints due to the patient pulling out oxygen nasal tubing and nasogastric feeding tube. The "Restraints" portion of the 9/19/08 "Patient Care Record" indicated staff initialed off 24 hours of 2 hour intervals (0800 - AM through 0600 - AM). The written entries included: A. "Patient bilateral wrist restraints released every 2 hours and when family member supervises the patient for circulation, hydration, redness noted, all pulses of upper extremities present." B. six entries were all recorded as "Checked circulation." The "Patient Care Notes" portion recorded: A. 1430 (2:30 PM) "..checked for circulation in bilateral restraints , all pulses present." The "Restraints" portion of the 9/21/08 "Patient Care Record" indicated staff initialed off 24 hours of 2 hour intervals (0800 - 8 AM through 0600 - AM). There were 2 written entries: A. "Patient bilateral wrist restraints removed every 2 hours or when family member supervises the patient. Restraints removed for circulation all pulse present, no redness or edema noted. Patient given ice chips, oral done frequently" and B. "Bilateral wrist restraints on patient pulled ng tube. Checked restraints q (every) 2 hours released at times for circulation."	A 186		

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A 186	Continued From page 60 The "Patient Care Notes" portion recorded: A. 1200 (noon) "...patient calm resting on the bed, Bilateral wrist restraints removed, patient wife monitors the patient." B. 1400 (2 PM) "patient calm resting in bed wife supervises bilateral wrist restraints off..." The record contained no documented evidence less restrictive measures and alternatives were tried. The facility presented five different policies on the use of restraint. 1. The facility policy titled "Restraints (undated), 6 pages, on page 4 was "References: Medicare Hospital Conditions of Participation: Patient Rights; JCAHO (Joint Commission Accreditation): 2004 Patient Care Standards." - on page 1, item 3 - "The use of the least restrictive method that meets the patient needs will be applied only after alternative methods have been attempted and failed to meet patient needs (see Attachment A - A listed examples of alternatives i.e. diversion activities, communication skills, environment). Alternative measures must be documented. - on page 2, item 4 - "....alternatives must be documented..." - on page 3, item c - "Reason for the restraint, ...For Safety is not acceptable." 2. The facility policy titled "Nursing Services, 309km, Restraint Procedure, 4 pages dated 7/93 with the most current revision dated 12/06, approval signatures were dated 1/2/07 and 1/8/07" documented the following: - on page 2 item policy 3 - "The use of the least	A 186		

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A 186	Continued From page 61	A 186		

restrictive method that meets the patient needs will be applied only after alternative methods have been attempted and failed to meet patient needs (see Attachment A - A listed examples of alternatives i.e. diversion activities, communication skills, environment). Alternative measures must be documented."
- on page 2 item policy 4 - "Initial assessment, continuous, and alternatives must be documented..."
- on page 2 item 5a - "an RN (registered nurse) must assess the patient daily to determine the need..."

3. The facility policy titled "Nursing Services, 309gf, Restraint Procedure, 5 pages dated 7/93 with the most current revision dated 12/03, no approval signatures were on the procedure" documented:

- The items mirrored the later approved version (as listed above).

4. There was 1 set of procedures identified as follows:

- on page R-5, item procedures 2 - "The IDT (interdisciplinary team) meets as soon as possible to review the assessment, and consider if all alternatives and interventions have been selected and implemented .....maintain the highest level of functioning with the least restrictive measures."
- on page R-6, item 4 - "All alternatives attempted prior to consideration of using restraint are documented in the patient's medical record."
- on page R-6, item 10 - "It is further expected...care plans indicate the need for restraints the facility engages in a systematic and

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A 186	Continued From page 62 gradual process towards reducing restraints." - on page R-7-12 are the sample forms to be used for: Physical Restraint Assessment; Follow-up; Chart Checklist; Informed Consent; Care Plan - Physical Restraint; and Tracking and Trending Log. 5. On 9/25/08 in the afternoon, the Acting DON (Director of Nursing) reported the policies provided were the policies utilized by the facility.	A 186		
A 194	482.13(f) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or Seclusion: Staff Training Requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff. This STANDARD is not met as evidenced by: Based on interview the facility failed to ensure the patient's right to safe implementation of restraint by ensuring staff were trained on the safe implementation of restraint use. Findings Include: 1. On 9/26/08 in the morning, the Staff Developer presented a Nursing Policies and Procedures on Restraints and indicated this restraint policy (Titled: "What You Need to Know, Untying the Mysteries of Restraints"; Section III Nursing Policies and Procedures, Restraint, original: 3/2006, Revision 3/2008) was what corporate wanted the facility to utilize. The Staff Developer reported she just began (first training session 9/9/08 and the second 9/17/08) training the staff. The forms identified in the training were not present in the patient records.	A 194		

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A 194	Continued From page 63 2. Charge Nurses (RN) and Floor Nurses from each of the 6 units were interviewed on 9/25/08 beginning at 10:30 AM. The interviews revealed: - the staff had an idea of restraint use, but were not necessarily trained at the facility, an LPN (Licensed Practical Nurse) could not recall if she was trained by the facility, other staff remembered doing training on the computer, one staff reported competencies were completed yearly. A Registered Nurse (RN) reported she was not trained however she could go to her supervisor. - the staff were unsure of what the facility policy was and were unaware of where it was kept. - the staff were unsure of where to obtain restraints and what to do with them after they were removed. Some staff thought restraints were kept in the supply room, others said restraints were kept in the laundry, another hall presented restraints that were kept on a cart on the unit. One RN stated she would throw away the wrist restraints and Posey vests after use. - the staff were unsure if they were to inform the family, some staff stated they would call the family unless it was night. - not all staff were aware of where to document restraint use. Most of the RNs reported they would document on the daily nursing notes. No one mentioned updating the Care Plan. - One RN mentioned least restrictive and alternative measures prior to restraint application.	A 194		
A 214	482.13(g) PATIENT RIGHTS: SECLUSION OR RESTRAINT	A 214		

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A 214	Continued From page 64 Death Reporting Requirements: Hospitals must report deaths associated with the use of seclusion or restraint. (1) The hospital must report the following information to CMS: Each death that occurs while a patient is in restraint or seclusion. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion. Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation. (2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient ' s death. (3) Staff must document in the patient's medical record the date and time the death was reported to CMS. This STANDARD is not met as evidenced by: Based on interview and policy review, the facility failed to ensure policies and procedures were in place to meet the requirements of reporting	A 214		

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A 214	Continued From page 65 restraint deaths. Findings Include: 1. Policy Review The facility did not have JCAHO (Joint Commission) accreditation. The facility provided 3 policies: a. "Subject: Death, Unusual and Adverse Incident Reporting, original 3/2006 (no updates), LP I - 32". - The policy did not include reporting any of the required information to CMS (Center for Medicaid and Medicare Services) in the required timelines. b. "Subject: Accident/Incident Reporting - Patient/Resident, original 3/2006 (no updates), LP I - 7". - The policy did not include reporting any of the required information to CMS (Center for Medicaid and Medicare Services) in the required timelines. - Item #11 on page 2 stated "To determine JCAHO reporting requirements refer to "Sentinel Events" (JCAHO) procedures, for incidents fall under that definition in the policy. c. "Subject: Sentinel Event for Joint Accredited Facilities, 2006, LP I - 74". - The entire restraint death policy/procedure was about reporting to Joint commission as opposed to CMS.	A 214		

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A 214	Continued From page 66 2. On 9/26/08 in the morning, the Acting Director of Nursing made no comment regarding the policy regarding reporting to Joint commission.	A 214		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on record review and interviews with the hospital administrator, the facility failed to meet the Condition of Participation (COP) for Quality Assurance Performance Improvement (QAPI). The facility did not develop, implement and maintain an effective, ongoing, hospital wide data driven quality assessment and performance improvement program for its contracted services (radiology, laboratory, housekeeping, oxygen, blood services, pest control and blood gas labs). Findings include: Review of the facility's quality assessment and performance improvement program did not reveal that contracted services were included in the	A 263		

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A 263	Continued From page 67 quality assurance performance improvement program. On 9/26/08 at 1:30 PM, the Hospital Administrator reported the hospital did not include contracted services in the QAPI program. The Administrator stated he met with the contracted services representatives quarterly. The Administrator reviewed quality assurance information provided by the contractors yearly but did not have a record of the information available in the facility.	A 263		
A 386	482.23(a) ORGANIZATION OF NURSING SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the Director of Nursing failed to determine the number of registered nursing personnel necessary to provide nursing care to all areas of the hospital. Findings Include: 1. On 09/23/08 through 09/26/08 during the day shift, Licensed Practical Nurses (LPNs) were assigned and observed functioning as charge or lead nurses on the 400, 500 and 600 units of the facility. There were no Registered Nurses (RN) physically present and on duty at all times on the	A 386		

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A 386	Continued From page 68 400, 500 and 600 units of the facility during the day shift. The LPNs were observed making patient assignments and directing patient care without supervision from a Registered Nurse physically present on the units. 2. On 09/24/08 at 1:20 PM, the Acting Director of Nursing (DON) reported the LPNs were frequently assigned and utilized as lead or charge nurses on the 300, 400, 500 and 600 units of the facility on the day and night shifts. The LPNs had been utilized as charge nurses for at least the past 2 1/2 years. The 100 and 200 units were assigned an RN as the charge nurse due to the high acuity of the patients on those units. The Acting DON reported the lead LPNs duties included making patient assignments and directing patient care on the units. Supervisors and an RN were called to the 300, 400, 500 and 600 units to perform nursing functions outside the scope of practice of the lead LPNs, such as PICC (peripherally inserted central catheter) line flushes and IV (intravenous) push medication administration. The Acting DON reported she was not aware Registered Nurses were required to be physically present on each unit of the facility to supervise and be available for immediate bedside care of patients. The Acting DON confirmed Registered Nurses were usually not staffed on the 400 through 600 units of the facility. 3. On 09/25/08 at 10:30 AM, LPN # 24 acknowledged being the day shift lead and charge nurse for the 500 unit of the facility. LPN #1 reported it was her responsibility to assign patients to the other LPNs and Certified Nurse	A 386		

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Assistants (CNAs) assigned to work on the unit. LPN # 24 reported the patient assignments were not based on acuity or diagnosis. Assignments were based on the number of patients on the "A" side and "B" side of the unit. One LPN was assigned the patients on the "A" side of the unit and an LPN was assigned the patients on the "B" side of the unit. CNAs were assigned to the "A" and "B" side of the unit. LPN # 24 reported if an IV push medication or PICC line flush was needed she would call one of the RNs assigned to the 100 or 200 unit, or a supervisor to respond to the unit to perform those functions of patient care.

LPN # 24 was asked what she would do if a patient coded on her unit. LPN # 24 reported RNs from the 100 or 200 units would respond to the emergency and run the code. LPN #24 acknowledged she had never checked the crash cart on the unit and reported that was an RNs function.

4. On 09/25/08 at 10:20 AM, LPN #25 acknowledged being the day shift lead and charge nurse for the 600 unit of the facility. LPN #25 reported her responsibilities included making patient assignments, directing patient care and transcribing physician orders. LPN #25 reported patient assignments were not based on acuity or diagnosis but on number of patients on the "A" side or "B" side of the unit. An LPN and a CNA were assigned to the "A" side and "B" side of the unit. LPN #25 confirmed no RNs were assigned or present on the 600 unit to supervise or direct patient care or to make patient assignments. A supervisor or RN had to be called to the unit to perform nursing functions outside the scope of practice for an LPN such as PICC line flushes

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A 386	Continued From page 70 and IV push medication administration. 5. A review of the facility's staffing records from 09/04/08 to 09/26/08 indicated the following deficiencies in RN staffing of the facility's inpatient units. On 09/04/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 500 or 600 units. On 09/05/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 400, 500 or 600 units. On 09/06/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 400 and 600 units. On 09/07/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 300 and 400 units. On 09/10/08 from 7:00 AM to 7:00 PM, no RN was listed on the facility staffing logs for the 500 unit. On 09/11/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 500 or 600 units. On 09/12/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 400 or 600 units. On 09/13/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 400 unit. From 7:00 PM to 7:00 AM, no RNs were staffed for the 600 unit. On 09/14/08 from 7:00 AM to 7:00 PM, no RNS were listed on the facility staffing logs for the 300 or 400 units. On 09/15/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing log for the 500 unit. On 09/18/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 400, 500 or	A 386		

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A 386	Continued From page 71 600 units. On 09/19/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 400, 500 or 600 units. On 09/20/08 from 7;00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 400 or 600 units. On 09/21/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 300 or 400 units. On 09/22/08 from 7:00 PM to 7:00 AM, no RNs were listed on the staffing logs for the 600 unit. On 09/24/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 300, 500 and 600 units. On 09/25/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 500 and 600 units. On 09/26/08 from 7:00 Am to 7:00 PM, no RNs were listed on the staffing logs for the 400 and 500 units. A new hire RN was being orientated to the 600 unit by the lead LPN. A review of facilities staffing policy and procedures indicated the facility will provide a sufficient number of staff to successfully implement patient focused functions. The facility would provide qualified personnel based on the organizations mission, scope of services provided, the population served, and federal and state certification and licensure requirements.	A 386		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when	A 392		

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needed, the immediate availability of a registered nurse for bedside care of any patient.

This STANDARD is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure there were licensed Registered Nurses (RN) assigned to each unit of the hospital who were physically present to ensure supervision and the immediate availability of a Registered Nurse for bedside care of any patient.

Findings Include:

1. On 09/23/08 through 09/26/08 during the day shift, Licensed Practical Nurses (LPNs) were assigned and observed functioning as charge or lead nurses on the 400, 500 and 600 units of the facility. There were no RNs physically present and on duty at all times on the 400, 500 and 600 units of the facility during the day shift. The LPNs were observed making patient assignments and directing patient care without supervision from an RN physically present on the units.

2. On 09/24/08 at 1:20 PM, the Acting Director of Nursing (DON) reported the LPNs were frequently assigned and utilized as lead or charge nurses on the 300, 400, 500 and 600 units of the facility on the day and night shifts. The LPNs had been utilized as charge nurses for at least the past 2 1/2 years. The 100 and 200 units were assigned an RN as charge nurse due to the high acuity of the patients on those units.

The Acting DON reported the lead LPNs duties included making patient assignments and directing patient care on the units. Supervisors and RNs were called to the 300, 400, 500 and

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A 392	Continued From page 73 600 units to perform nursing functions outside the scope of practice of the lead LPNs such as PICC (peripherally inserted central catheter) line flushes and IV (intravenous) push medication administration. The Acting DON reported she was not aware RNs were required to be physically present on each unit of the facility to supervise and be available for immediate bedside care of patients. The Acting DON confirmed RNs were usually not staffed on the 400 through 600 units of the facility. 3. On 09/25/08 at 10:30 AM, LPN # 24 acknowledged being the day shift lead and charge nurse for the 500 unit of the facility. LPN # 24 reported it was her responsibility to assign patients to the other LPNs and Certified Nurse Assistants (CNA) assigned to work on the unit. LPN # 24 reported the patient assignments were not based on acuity or diagnosis. Assignments were based on the number of patients on the "A" side and "B" side of the unit. One LPN was assigned the patients on the "A" side of the unit and an LPN was assigned the patients on the "B" side of the unit. CNAs were assigned to the "A" and "B" side of the unit. LPN # 24 reported if an IV push medication or PICC line flush was needed she would call one of the RNs assigned to the 100 or 200 unit, or a supervisor to respond to the unit to perform those functions of patient care. LPN # 24 was asked what she would do if a patient coded on her unit. LPN # 24 reported RNs from the 100 or 200 units would respond to the emergency and run the code. LPN #24 acknowledged she had never checked the crash cart on the unit and reported that was an RNs	A 392		

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A 392	Continued From page 74 function. 4. On 09/25/08 at 10:20 AM, LPN # 25 acknowledged being the day shift lead and charge nurse for the 600 unit of the facility. LPN #25 reported her responsibilities included making patient assignments, directing patient care and transcribing physician orders. LPN #25 reported patient assignments were not based on acuity or diagnosis but on number of patients on the "A" side or "B" side of the unit. An LPN and a CNA were assigned to the "A" side and "B" side of the unit. LPN #25 confirmed no RNs were assigned or present on the 600 unit to supervise or direct patient care or to make patient assignments. A supervisor or RN had to be called to the unit to perform nursing functions outside the scope of practice for an LPN such as PICC line flushes and IV push medication administration. 5. A review of the facilities staffing records from 09/04/08 to 09/26/08 indicated the following deficiencies in RN staffing of facilities inpatient units. On 09/04/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 500 or 600 units. On 09/05/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 400, 500 or 600 units. On 09/06/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 400 and 600 units. On 09/07/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 300 and 400 units. On 09/10/08 from 7:00 AM to 7:00 PM, no RN was listed on the facility staffing logs for the 500	A 392		

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A 392	Continued From page 75 unit. On 09/11/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 500 or 600 units. On 09/12/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 400 or 600 units. On 09/13/08 from 7:00 AM to 7:00 PM, no RNs were listed on the facility staffing logs for the 400 unit. From 7:00 PM to 7:00 AM, no RNs were staffed for the 600 unit. On 09/14/08 from 7:00 AM to 7:00 PM, no RNS were listed on the facility staffing logs for the 300 or 400 units. On 09/15/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing log for the 500 unit. On 09/18/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 400, 500 or 600 units. On 09/19/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 400, 500 or 600 units. On 09/20/08 from 7;00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 400 or 600 units. On 09/21/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 300 or 400 units. On 09/22/08 from 7:00 PM to 7:00 AM, no RNs were listed on the staffing logs for the 600 unit. On 09/24/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 300, 500 and 600 units. On 09/25/08 from 7:00 AM to 7:00 PM, no RNs were listed on the staffing logs for the 500 and 600 units. On 09/26/08 from 7:00 Am to 7:00 PM, no RNs were listed on the staffing logs for the 400 and 500 units. A new hire RN was being orientated to	A 392		

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A 392	Continued From page 76 the 600 unit by the lead LPN. A review of facilities staffing policy and procedures indicated the facility will provide a sufficient number of staff to successfully implement patient focused functions. The facility would provide qualified personnel based on the organizations mission,scope of services provided, the population served, and federal and state certification and licensure requirements.	A 392		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a Registered Nurse (RN) was assigned to supervise and evaluate the nursing care upon admission and when appropriate for 9 of 36 patients (#6, #9, #10, #18, #20, #22, #29, #34, #35). Findings include: On 09/23/08 through 09/26/08 during the day shift, Licensed Practical Nurses (LPN) were assigned and observed functioning as charge or lead nurses on the 400, 500 and 600 units of the facility. There were no RNs physically present and on duty at all times on the 400, 500 and 600 units of the facility during the day shift. The LPNs were observed making patient assignments and directing patient care without supervision from an RN physically present on the units. 1. Patient # 6 was admitted to the facility on 08/20/08 with diagnoses including Abdominal	A 395		

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A 395	Continued From page 77 Pain, Peritonitis, Status Post Exploratory Laparotomy. No nursing care plan was located in the patients chart or the units nursing care binder. On 09/23/08 at 4:00 PM, Charge Nurse #26 reported she could not locate a nursing care plan for Patient #6. Charge Nurse #26 indicated a nursing care plan for Patient #6 must not have been completed. The Charge Nurse reported it was the RN responsibility to initiate nursing care plans on patients admitted to the facility. 2. Patient # 9 was admitted to the facility on 08/28/08, with diagnoses including Respiratory Failure, End Stage Chronic Obstructive Pulmonary Disease, Pneumonia and Hypertension. No nursing care plan was located in the patients chart or the units nursing care binder. On 09/23/08 at 4:00 PM, Charge Nurse #26 reported she could not locate a nursing care plan for Patient #9. 3. Patient # 18 was admitted to the facility on 09/13/08 with diagnoses including Clostridium Difficile Colitis, Atrial Fibrillation and Gluteal Decubitus Stage II Ulcer. No nursing care plan was located in the patients chart or the nursing units nursing care binder. On 09/24/08 at 2:00 PM, Lead LPN #27 reported she could not locate a nursing care plan for Patient #18. LPN #27 indicated it was the RNs responsibility to initiate and update nursing care plans on the patients. LPN #27 reported there were no RNs staffed on the unit on day shift who could initiate a nursing care plan for Patient #18.	A 395		

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4. Patient #10 was admitted to the facility on 09/03/08 with diagnoses including Diabetes, Abdominal Wound Infection and End Stage Renal Disease. Physician orders dated 09/22/08 included Lantus insulin 15 units subcutaneously every evening and Total Parental Nutrition. The patients nursing care plan under "alteration in elimination" and "alteration in blood glucose levels" were left blank with no entries filled out by the nursing staff.

On 09/23/08 at 3:45 PM, Charge Nurse #26 reported nursing care plans are updated daily at the end of each shift when chart checks are done. Charge Nurse #26 indicated the care plan for Patent #10 should have been updated by the charge nurse.

5. Patient #20 was admitted to the facility on 09/17/08 with diagnoses including Morbid Obesity, Atrial Flutter, Hypertension, Bronchitis and Bilateral Knee Replacements. Physicians orders dated 09/21/08 included discontinuing the Foley catheter and bladder training. The patients nursing care plan under "alteration in elimination" and "alteration in cardiac output" were left blank with no entries filled out by the nursing staff.

6. Patient #24 was admitted to the facility on 09/03/08 with diagnoses including Diarrhea, Leukocytosis, and Dehydration. A physicians order dated 09/08/08 included a followup stool specimen culture for Clostridium Difficile Colitis. The patients nursing care plan under "fluid volume deficit" and "alteration in elimination" were left blank with no entries filled out by the nursing staff.

On 09/24/08 at 1:20 PM, the Acting Director of

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Nursing (DON) reported RNs were responsible for initiating a nursing care plan on each patient admitted to the facility and updating the nursing care plan to address any new patient problems, expected outcomes, goals and interventions. Licensed Practical Nurses may add to the nursing care plan when appropriate.

The Acting DON acknowledged that since LPNs were utilized as charge nurses on the 300, 400, 500 and 600 units in the facility on a frequent basis they would not be initiating nursing care plans on patients admitted to those units. The Acting DON acknowledged lead LPNs were supervising and evaluating nursing care to patients on the above mentioned units of the facility. The Acting DON reported she was not aware a Registered Nurse must be physically present on each unit of the facility to provide ongoing assessments and care of patients.

7. Patient #29 was admitted to the facility on 9/20/08 with diagnoses including Acute Renal Failure on dialysis, Coagulase-Positive Bacteremia, Chronic Anemia and Pleural Effusion.

Review of Patient #29's admission orders included a urinalysis with culture and sensitivity (UA with C/S). Review of the physician's orders on 9/22/08 at 12:28 PM revealed, an order was written for "Stool for occult blood x2."

On 9/25/08 at 8:00 AM, requisitions for UA with C/S and Stool for occult blood was found in the Certified Nurses Assistant's (CNA) binder.

On 9/25/08 at 8:00 AM, Employee #22 revealed, the CNAs were responsible in making sure

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A 395	Continued From page 80 specimens were collected to be sent to laboratory. Employee #22 further revealed, physicians were to re-write the order if the specimens were not sent after two days of the original order, and/or to simply remind the staff the original order had not been carried out. On 9/25/08 at 8:20 AM, Employee #21 revealed, the charge nurses were responsible in making sure all orders were carried out. Employee #21 further revealed, it was difficult to make sure specimens were collected by CNAs due to: - The laboratory requisitions were given to the CNAs - The CNAs kept the requisition forms until the specimens were collected. - There was no process in place to ensure all specimens needed were being collected in a timely manner. On 9/25/08 at 11:00 AM, interview with the Acting Director of Nursing revealed, the was no policy and procedure available for specimen collection. 8. Patient #34 was admitted to the facility on 9/5/08 with diagnoses including Congestive Heart Failure, Cardiopathy, and Atrial Fibrillation. On 9/24/08 at 2:00 PM, a requisition form for stool for occult blood screening x 2 was found in a Certified Nurses Assistant's (CNA) binder. On 9/24/08, Patient #34 was in room 216 A in the morning, and was transferred to room 629B by 3:00 PM.	A 395		

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A 395	Continued From page 81 The order for stool for occult blood was ordered on 9/18/08. On 9/24/08 at 3:00 PM, Employee #25 who admitted Patient #34 to the unit revealed, there was no documentation nor any endorsement that Patient #34 needed to be checked for occult blood in the stool. Employee #25 added, " I got report but I was not told about needing stool for occult blood." On 9/24/08 at 3:00 PM, Employee #25 revealed, there was no documentation in the patient's kardex indicating needed stool specimen for occult blood. On 9/25/08 at 9:15 AM, Employee #25 revealed, the stool sample had not been sent. Employee #25 further indicated, the physician had made another written order to "make sure it gets done." 9. Patient #35 was admitted to the facility on 9/9/08 with diagnoses including Chronic Kidney Disease, Obstructive Uropathy, Status Post Exploratory Laparotomy and Resection, and Large B-Cell Lymphoma. On 9/25/08 at 8:00 AM, a requisition for stool for occult blood x 3 was found in the Certified Nurses Assistant's (CNA) binder. The order was written on 9/22/08 at 12:40 PM. Nurses notes indicated, Patient #35 had a bowel movement (BM) within the morning shift x1, once within the night shift, and once within the night shift of 9/23/08.	A 395		

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A 395	Continued From page 82 On 9/25/08 at 8:00 AM, Employee #22 revealed, Patient #35 had not had a bowel movement for 4 days. When Employee #22 was shown the nurses notes indicating Patient #35's BMs, Employee #22 further stated, the CNAs were responsible in making sure specimens were collected. Employee #22 also revealed, if the specimens were not sent after two days of the original order was made, the physicians were to re-write the order and/or to simply remind the staff that the original order had not been carried out. On 9/25/08 at 11:00 AM, interview with the Acting Director of Nursing revealed, there was no policy and procedure available for specimen collection.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the nursing staff developed or kept current a nursing care plan for 7 out of 36 patients (#6, #9, #10, #18, #20, #21, #24). Findings include: 1. Patient # 6 was admitted to the facility on 08/20/08 with diagnoses including Abdominal Pain, Peritonitis, Status Post Exploratory Laparotomy. No nursing care plan was located in the patients chart or the units nursing care binder.	A 396		

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A 396	Continued From page 83 On 09/23/08 at 4:00 PM, Charge Nurse #26 reported she could not locate a nursing care plan for Patient #6. Charge Nurse #26 indicated a nursing care plan for Patient #6 must not have been completed. The Charge Nurse reported it was the Registered Nurses responsibility to initiate nursing care plans on patients who are admitted to the facility. 2. Patient # 9 was admitted to the facility on 08/28/08 with diagnoses including Respiratory Failure, End Stage Chronic Obstructive Pulmonary Disease, Pneumonia and Hypertension. No nursing care plan was located in the patients chart or the units nursing care binder. On 09/23/08 at 4:00 PM, Charge Nurse #26 reported she could not locate a nursing care plan for Patient #9. 3. Patient #18 was admitted to the facility on 09/13/08 with diagnoses including Clostridium Difficile Colitis, Atrial Fibrillation and Gluteal Decubitus Stage II Ulcer. No nursing care plan was located in the patients chart or the nursing units nursing care binder. On 09/24/08 at 2:00 PM, Lead LPN #27 reported she could not locate a nursing care plan for Patient #18. LPN #27 indicated it was the Registered Nurses responsibility to initiate and update nursing care plans on the patients. LPN #27 reported there were no Registered Nurses staffed on the unit on day shift who could initiate a nursing care plan for Patient #18. 4. Patient #10 was admitted to the facility on 09/03/08 with diagnoses including Diabetes,	A 396		

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A 396	Continued From page 84 Abdominal Wound Infection and End Stage Renal Disease. Physician orders dated 09/22/08 included Lantus insulin 15 units subcutaneously every evening and Total Parenteral Nutrition. The patients nursing care plan under "alteration in elimination" and "alteration in blood glucose levels" were left blank with no entries filled out by the nursing staff. On 09/23/08 at 3:45 PM, Charge Nurse #26 reported nursing care plans are updated daily at the end of each shift when chart checks are done. Charge Nurse #26 indicated the care plan for Patent #10 should have been updated by the charge nurse. 5. Patient #20 was admitted to the facility on 09/17/08 with diagnoses including Morbid Obesity, Atrial Flutter, Hypertension, Bronchitis and Bilateral Knee Replacements. Physicians orders dated 09/21/08 included discontinuing the Foley catheter and bladder training. The patients nursing care plan under "alteration in elimination" and "alteration in cardiac output" were left blank with no entries filled out by the nursing staff. 6. Patient #21 was admitted to the facility on 9/3/08 with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure and Chronic Back Pain. A nursing care plan was initiated on 9/3/08, however, there was no documentation in the nursing care plan addressing Patient #21's chronic back pain. 7. Patient # 24 was admitted to the facility on 09/03/08 with a diagnosis that included Diarrhea, Leukocytosis, and Dehydration. A physicians order dated 09/08/08 included a followup stool	A 396		

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A 396	Continued From page 85 specimen culture for Clostridum Difficile Colitis. The patients nursing care plan under "fluid volume deficit" and "alteration in elimination" were left blank with no entries filled out by the nursing staff.	A 396		
A 397	482.23(b)(5) PATIENT CARE ASSIGMENTS A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure a Registered Nurse assigned the nursing care of each patient to other nursing personnel according to the patients needs and the qualifications and competence of the nursing staff available. Findings Include: 1. On 09/23/08 through 09/26/08 during the day shift, Licensed Practical Nurses (LPNs) were assigned and observed functioning as charge or lead nurses on the 400, 500 and 600 units of the facility. There were no Registered Nurses physically present and on duty at all times on the 400, 500 and 600 units of the facility during the day shift. The LPNs were observed making patient assignments and directing patient care without supervision from a Registered Nurse physically present on the units. 2. On 09/24/08 at 1:20 PM, the Acting Director of Nursing (DON) reported the LPNs were frequently assigned and utilized as lead or charge nurses on the 300, 400, 500 and 600 units of the	A 397		

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A 397	Continued From page 86	A 397		

facility on the day and night shifts. The LPNs had been utilized as charge nurses for at least the past 2 1/2 years. The 100 and 200 units were assigned a Registered Nurse as charge nurse due to the high acuity of the patients on those units.

The Acting DON reported the lead LPNs duties included making patient assignments and directing patient care on the units. The lead LPNs were responsible for assigning other LPNs and Certified Nurse Assistants (CNAs) to an "A" side or "B" side of each unit on the 300, 400, 500 and 600 units. The patient assignments were based on numbers of patients not on acuity, diagnosis or qualifications and competence of the nursing staff. Supervisors and Registered Nurses were called to the 300, 400, 500 and 600 units to perform nursing functions outside the scope of practice of the lead LPNs such as PICC (peripherally inserted central catheter) line flushes and IV (intravenous) push medication administration.

The Acting DON reported she was not aware Registered Nurses were required to be physically present on each unit of the facility to supervise, make patient assignments and be available for immediate bedside care of patients. The Acting DON confirmed Registered Nurses were usually not staffed on the 400 through 600 units of the facility. The Acting DON reported she worked with the staffing coordinator to assign lead LPNs, LPNs and CNAs to the above mentioned units but it was left to the lead LPNs to make the patient assignments on the units.

3. On 09/25/08 at 10:30 AM, LPN #24 acknowledged being the day shift lead and

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A 397	Continued From page 87 charge nurse for the 500 unit of the facility. LPN #24 reported it was her responsibility to assign patients to the other LPNs and CNAs assigned to work on the unit. LPN #24 reported the patient assignments were not based on acuity or diagnosis. Assignments were based on the number of patients on the "A" side and "B" side of the unit. One LPN was assigned the patients on the "A" side of the unit and an LPN was assigned the patients on the "B" side of the unit. CNAs were assigned to the "A" and "B" side of the unit. LPN #24 reported if an IV push medication or PICC line flush was needed she would call one of the Registered Nurses assigned to the 100 or 200 unit, or a supervisor to respond to the unit to perform those functions of patient care. LPN #24 confirmed Registered Nurses did not make the patient assignments on the 500 unit. LPN #24 was asked what she would do if a patient coded on her unit. LPN #24 reported Registered Nurses from the 100 or 200 units would respond to the emergency and run the code. LPN #24 acknowledged she had never checked the crash cart on the unit and reported that was a Registered Nurses function. 4. On 09/25/08 at 10:20 AM, LPN #25 acknowledged being the day shift lead and charge nurse for the 600 unit of the facility. LPN #25 reported her responsibilities included making patient assignments, directing patient care and transcribing physician orders. LPN #25 reported patient assignments were not based on acuity or diagnosis but on number of patients on the "A" side or "B" side of the unit. An LPN and a CNA were assigned to the "A" side and "B" side of the unit. LPN #25 confirmed no Registered Nurses were assigned or present on the 600 unit to	A 397		

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A 397	Continued From page 88 supervise or direct patient care or to make patient assignments. A supervisor or Registered Nurse had to be called to the unit to perform nursing functions outside the scope of practice for an LPN such as PICC line flushes and IV push medication administration. 5. On 09/23/08 through 09/26/08, a review of the patient assignment sheets on the 300 through 600 units of the facility indicated the lead LPNs filled out the assignment sheets and documented the nursing staff assignments on a bulletin board on the units.	A 397		
A 404	482.23(c) ADMINISTRATION OF DRUGS Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow physician's orders for 3 of 36 patients (#31, #32, #33). Finding include: 1. Patient #31 was admitted to the facility on 9/18/08 with diagnoses including Hypokalemia, Status Post Respiratory Failure, Cushings Syndrome, Addison's Disease and Chronic Back Pain. On 9/21/08, a physician ordered for Patient #31 to receive K-Dur (potassium chloride supplement) 10 mEq (milliequivalent) PO (by mouth) everyday. Patient #31's potassium level on 9/21/08 was 3.2,	A 404		

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A 404	Continued From page 89 with the normal range being 3.5 to 5.3 mEq/L (milliequivalent/liter). On 9/25/08, review of the Medication Administration Record (MAR) revealed, Patient #31 received the first dose of K-Dur on 9/23/08 at 9:00 AM. On 9/25/08 at 8:30 AM, Employee #9 revealed, there was no documentation as to why Patient #31 received the first dose of K-Dur on 9/25/08 as opposed to 9/21/08. 2. Patient #32 was admitted to the facility on 9/18/08 with diagnoses including Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident with Right Sided Hemiparesis, Chronic Dysphagia, Status Post Percutaneous Endoscopic Gastrostomy (PEG). On 9/25/08 at 11:10 AM, review of the medication administration record (MAR) revealed, Patient #32's Theophylline 80 mg (milligram)/15 cc (cubic centimeter) was due at 9:00 AM. The medication had not been given at 11:10 AM. On 9/25/08 at 11:10 AM, review of the MAR revealed, Patient #32's Prilosec 20 mg was also due at 9:00 AM. The medication had not been given at 11:10 AM. On 9/25/08 at 11:10 AM, Employee #29 revealed, the Theophylline bottle did not have 15 cc to give to the patient. The contracted pharmacy had been notified and the facility was waiting for delivery. Prilosec over-the-counter (OTC) 20 mg by mouth was in the process of being changed. A phone	A 404		

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A 404	Continued From page 90 call had been placed to the physician. Employee #29 further revealed, Patient #32 had a PEG tube and had been receiving the medication through it, since the patient had chronic dysphagia. The Prilosec tablet was one medication that could not be given crushed. On 9/25/08 at 10:34 AM, a faxed receipt for the contract pharmacy revealed, the Theophylline was re-ordered for Patient #32. On 9/25/08, review of the facility's list of "Medications Not To Be Crushed", Prilosec was one of the medications listed. 3. Patient #33 was admitted to the facility on 9/17/08 with diagnoses including Osteoarthritis and Status Post Left Total Knee Arthroplasty. On 9/25/08 at 8:15 AM during medication pass, Employee #10 did not give Niacin 500 mg by mouth and Fish Oil 1000 mg by mouth to Patient #33. Upon medication preparation for Patient #33, Employee #10 was observed circling her initials on the medication administration record (MAR) to both scheduled medications, prior to going to Patient #33's room. On 9/25/08 at 8:15 AM, Employee #10 revealed, Patient #33 had been refusing to take the Niacin and the Fish Oil for at least a week. Employee #10 indicated in the past, Patient #33 had stated, the patient would resume the medications once the patient was home.	A 404		

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A 404	Continued From page 91 Employee #10 was not sure if the attending physician had been notified of patient's continued medication refusal. On 9/25/08 at 8:30 AM, Employee #9 revealed, she was not aware of Patient #33's refusal to take Niacin and Fish Oil tablets. Employee #9 further stated, "I was not aware the patient was refusing the medications. I would have notified the physician from the very first day the patient had refused." On 9/25/08, Patient #33's medication administration record (MAR) revealed, Niacin had not been taken since 9/21/08, and the Fish Oil tablet had not been taken since 9/17/08. Niacin 500 mg by mouth (PO) daily was ordered on 9/17/08. Fish Oil 1000 mg PO twice a day was also ordered on 9/17/08.	A 404		
A 406	482.23(c)(2) WRITTEN MEDICAL ORDERS FOR DRUGS With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under §482.12(c). This STANDARD is not met as evidenced by: Based on record review, the facility failed to comply with the medical staff bylaws which indicate, documented verbal orders were to be	A 406		

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A 406	Continued From page 92 signed off by the ordering practitioner within 48 hours for 1 of 36 patients (#12). Findings include: 1. On 9/24/08, the following verbal orders for Patient #12 were found and were not signed off by the ordering practitioner. These orders exceeded the 72 hour CMS (Center for Medicaid and Medicare Services) requirement. - 9/14/08 at 12:00 PM: "Lortab 5/500mg (milligram) 1 tablet PO (by mouth) every 4 hours PRN (as needed) for pain." - 9/20/08 (no time indicated): "Change right heel with N.S. (normal saline) Pat dry. Wrap with Kerlix QD (every day) by nursing." On 9/24/08 at 3:30 PM, the Acting Director of Nursing revealed, the physicians normally signed off the telephone and verbal orders the next day after the orders were given. The two orders were missed by the physician. On 9/24/08, the hospital's Acting DON indicated, the hospital followed the Nevada Nurse Practice Act and in accordance with the hospital's Practice Guidelines. There was no hospital Practice Guidelines found by the Acting DON regarding telephone and verbal orders.	A 406		
A 494	482.25(a)(3) PHARMACY DRUG RECORDS Current and accurate records must be kept of the receipt and distribution of all scheduled drugs. This STANDARD is not met as evidenced by: Based on interview, the hospital failed to keep a	A 494		

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A 494	Continued From page 93 current and accurate tracking system of all scheduled drugs, from the point of entry into the hospital to the point of disposal. Findings include: On 9/23/09 at 9:30 AM, interview with the hospital Pharmacist revealed the following: - There was no policy and procedure currently in place to ensure disposal of scheduled drugs were accurate from the time the scheduled drugs were endorsed to the hospital Pharmacist for disposal. - The only available form was the "LTC (Long Term Care) Controlled Substance Destruction Signature Form" to indicate, narcotic medications were being transported back to the contract pharmacy for destruction. This form was signed by the Pharmacist and Director of Nursing. - The hospital Pharmacist transported the narcotic medications for disposal to the contracted pharmacy. - The narcotic medications were transported via tamper-proof container. - There was no inventory nor a reconciliation process between the pharmacist and contracted pharmacy upon relinquishment of the narcotic medications. - It was assumed, all medications were accounted for upon delivery. However, the "LTC Controlled Substance Destruction Signature Form" which was signed at the hospital by the Pharmacist and the Director of Nursing was also given to contracted pharmacy. This form was then signed	A 494		

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A 494	Continued From page 94 again by the hospital Pharmacist and co-signed by a representative of contracted pharmacy. On 9/25/08 at 4:00 PM, interview with the Acting Director of Nursing (DON) revealed, there was no policy and procedure nor a tracking process that was currently in place, when discontinued narcotics were taken out of the facility to be returned to contracted pharmacy. The hospital's practice were as follows: - When a patient's narcotic medication had been discontinued by his or her physician, the medication was pulled from the pyxis machine and collected by the DON. - The medication was then kept in the DON's office, in a locked cabinet until it was collected by the hospital Pharmacist for return to the contracted pharmacy. - The Pharmacist and the hospital's DON or the Assistant Director of Nursing reconciled the narcotic medications for accuracy prior to its delivery to contracted pharmacy for disposal. - It was to the hospital Pharmacist's or the DON's discretion when scheduled drugs were to be delivered back to contracted pharmacy. - Deliveries were made every month to two months depending on the volume of narcotics to be returned to contracted pharmacy for disposal. - Once all narcotic medications were reconciled and accounted for by the hospital Pharmacist and Director of Nursing, each controlled drug receipt/disposition form to each narcotic medication container was then signed by the	A 494		

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A 494	Continued From page 95 Pharmacist and the DON. This form was kept in the patient's medical chart. - The "LTC Controlled Substance Destruction Signature Form" was initiated and signed by the Pharmacist and the DON for relinquishment, which was given to the contracted pharmacy upon delivery of the scheduled medications. This form was in turn, signed off by the receiving representative of the contracted pharmacy. - The narcotic medications were placed in a tamper-proof plastic container for delivery to contracted pharmacy. The hospital Pharmacist contacted the pharmacy to notify them of the day's delivery, and a time frame was set in which the travel time did not exceed one hour. - There was no log kept within the hospital other than the controlled drug receipt/disposition form, which was placed in the patient's medical chart. Per interviews conducted, the hospital did not have any documentation readily available to trace the movement of all scheduled drugs.	A 494		
A 502	482.25(b)(2)(i) SECURE STORAGE All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure all drugs and biologicals were kept in a secured area, not easily accessible by unauthorized individuals. Findings include: On 9/23/08, during the hospital tour at 8:00 AM,	A 502		

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A 502	Continued From page 96 the refrigerator for medication storage was found to be unlocked. On 9/23/08 at 8:10 AM, the 500 Hall was found to have unsecured medications on top of a pyxis box. These medications were: Nystatin suspension, Niaspan, Phoslo-gel capsules, ear wax remover drops, Buproprion SR and Carvedilol. On 9/23/08 at 8:10 AM, Employee #16 revealed, the medications had been discontinued and were awaiting to be picked up by a supervisor for disposal. Employee #16 added, the medications should have been kept in the small pyxis box against the wall, installed for that purpose. On 9/23/08 at 8:40 AM, a medication cart in the 600 Hall was found to be unlocked. Employee #18 stated, "Maintenance already worked on it but it's still not working; We have been having trouble with that cart for awhile now." On 9/23/08 at 8:50 AM, a plastic pink tray was found at the nurses' station with an open vial of Novolin Regular Insulin dated 8/30/08. On 9/23/08 at 8:50 AM, the Acting Director of Nursing (DON) stated, the vial of Novolin should have been locked up. On 9/23/08 at 9:00 AM, upon entering the rehabilitation department, a plastic bottle of Perineal Spray was found by the wooden shelf. On 9/23/08 at 9:10 AM, inside the physical therapy room, an open bottle of Vitamin B6 and an open bottle of Vitamin B12 tablets were found in an unlocked cabinet.	A 502		

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A 502	Continued From page 97 There were no hospital staff available for inquiry. On 9/24/08 at 8:40 AM, a syringe of Sodium Chloride flush with needle attached, was found at the bedside of Patient #25. The hospital administrator was immediately made aware of the finding who happened to walk by the patient's room. On 9/24/08 at 9:45 AM, an unsecured open vial of Novolin R labelled, "open date 8/31" was found in a pink plastic tray on the counter of 200 Hall nurses' station. On 9/25/08 at 9:45 AM, Employee #17 stated, "it's there because it is house supply and it is for everyone to use." On 9/25/08 at 9:55 AM, the Acting DON walked in to the unit and was made aware of the finding. The Acting DON took the vial of Novolin R and handed it to Employee #17 verbally instructing the employee to "lock this up." On 9/23/08 at 8:20 AM, the 100 hall medication refrigerator was observed to be unlocked and unattended by staff. The refrigerator was opened and found to contain three vials of Novolog Insulin, two vials of Novolin N, one vial of Novolin R Insulin, two vials of Lantus Insulin and one vial of Humolog Insulin. In addition, two vials of Aplisol were found. On 9/23/08 at 8:45 AM, the medication cart on the 300 hall was found to be unlocked and	A 502		

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A 502	Continued From page 98 unattended by staff. The drawers to the cart were easily opened and patient's medications could be removed. The Acting Director of Nursing was informed of the unlocked refrigerator and medication cart at 10:00 AM. The Acting Director of Nursing stated that staff "knew better" than to leave the medication storage areas unlocked.	A 502		
A 505	482.25(b)(3) UNUSABLE DRUGS NOT USED Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all outdated drugs were not available for patient use. Findings include: On 9/25/08 at 3:15 PM, an inventory of the 100 Hall crash cart was made with Employee #20. The 100 Hall crash cart was found to have the following expired medications: - Four of four Amiodarone 150 mg (milligram)/3 ml (milliliter) expired on July 1, 2008. - One of one D10% 1 Liter expired in July 2008. - One Dopamine 400 mg/250 ml expired in July 2008. There should have been three in the crash cart but only one was found. On 9/25/08 at 3:15 PM, Employee #20 revealed the following: - The 100 Hall crash cart medications should have been checked for complete number of	A 505		

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A 505	Continued From page 99 supplies and expirations dates. - On 9/22/08, the crash cart was opened on the night shift. - Employee #20 was not sure whether the night shift charge nurse or the following day shift charge nurse took an inventory of the crash cart. - Medications to supply the crash cart were directly ordered from contract pharmacy. - The contract pharmacy was given a list of medications via facsimile, to complete the par levels of each medications for the crash cart. - The crash cart was locked at all times regardless whether the par levels were complete or not. - Employee #20 was not sure how to determine if the par levels were complete due to the crash cart being locked at all times. On 9/25/08 at 8:25 AM, Employee #21 revealed the following: - It was the responsibility of the unit charge nurse and house supervisor to ensure the crash cart medications were complete and not outdated. - An inventory was made soon after an emergency. This was made by the unit charge nurse (100 or 500 Hall charge nurses where crash carts are located). - Missing medications and/or outdated medications were replenished by the charge nurse and the house supervisor through the hospital's emergency medication cabinet. - The emergency medication cabinets were located in the 200, 300 and 500 Halls. - The 200 and 300 Hall emergency medication cabinets were the "most complete" and the 300 Hall emergency medication cabinet was only accessed as a last resort to replenish the crash carts.	A 505		

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- When medications were taken out from any of the emergency medication cabinet, the contract pharmacy was notified via a telephone call.
- The contract pharmacy was to come in, to make an inventory and replenish the emergency medication cabinet (s).

Document Review on 9/25/08:

- The purpose of the hospital's policy and procedure indicated, "To ensure crash carts are fully stocked at all times with equipment medications and supplies needed in a code situation. To make sure equipment is in proper working order and also to ensure that expired medications are pulled and replaced on the crash carts".

- The hospital's maintenance of crash cart policy and procedure states, " Carts are to be restocked immediately after use by a designated person (s)."

- The was no documentation found in the policy and procedure to indicate who the designated persons were.

- "Locks are to be secured after cart has been refilled. When cart has been fully restocked and ready for use, numbered lock is to be replaced and recorded on the flow sheet."
- The 100 Hall crash cart was locked before it was refilled:
  - Four of four Amiodarone 150 mg/3 ml were all expired.
  - Based on the par level, there should have been 6 of Dextrose 50% amp. There were only 5 found in the crash cart.
  - Based on the par level, there should have

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A 505	Continued From page 101 been 10 of Epinephrine 0.1 mg/ml. There were only 5 found in the crash cart. - Based on the par level, there should have been 3 of Dopamine 400 mg/250 ml. There was only one found and it expired in July 2008. - "After the code, the Code Cart will be restocked and signed off by the House Supervisor/ADON and nurse who restocked." - There was no document found indicating the code cart was restocked. This was confirmed by Employee #20.	A 505		
A 585	482.27(a)(3) WRITTEN PROTOCOL FOR TISSUE SPECIMENS The laboratory must make provisions for the proper receipt and reporting of tissue specimens. This STANDARD is not met as evidenced by: Based on a review of policies and procedures and interviews with the clinical director of respiratory care and the director of nursing, the laboratory had no written instructions for the collection, preservation, transportation, receipt and reporting of tissue specimen results. The findings include: An interview with the clinical director of respiratory care on 9/23/2008 at 2:00 p.m. revealed there was no provision for the receipt and reporting of tissue specimens. The director of nursing, after reviewing the hospital policy and procedures, confirmed this on 9/25/2008 at 9:35 a.m.	A 585		
A 586	482.27(a)(4) POLICIES FOR LABORATORY SERVICES The medical staff and a pathologist must	A 586		

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A 586	Continued From page 102 determine which tissue specimens require a macroscopic (gross) examination and which require both macroscopic and microscopic examinations. This STANDARD is not met as evidenced by: Based on a review of policies and interviews with the clinical director of respiratory care and the director of nursing, there were no policies approved by the medical staff and a pathologist to determine which tissue specimens require a macroscopic and which require both a macroscopic and microscopic examinations. The findings include: There was no written policy for the examination of tissue specimens. This was confirmed by interviews with the clinical director of respiratory care on 9/23/2008 at 2:00 p.m. and the director of nursing on 9/25/2008 at 9:35 a.m.	A 586		
A 592	482.27(b) POTENTIALLY INFECTIOUS BLOOD/BLOOD PRODUCTS Standard: Potentially infectious blood and blood products. (1) Potentially human immunodeficiency virus (HIV) infectious blood and blood components. Potentially HIV infectious blood and blood components are prior collections from a donor - (i) Who tested negative at the time of donation but tests reactive for evidence of HIV infection on a later donation; (ii) Who tests positive on the supplemental (additional, more specific) test or other follow-up testing required by FDA; and (iii) For whom the timing of seroconversion cannot be precisely estimated.	A 592		

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A 592	Continued From page 103 (2) Potentially hepatitis C virus (HCV) infectious blood and blood components. Potentially HCV infectious blood and blood components are the blood and blood components identified in 21 CFR 610.47. (3) Services furnished by an outside blood collecting establishment. If a hospital regularly uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement must require that the blood collecting establishment notify the hospital -- (i) Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of HIV or HCV infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection; (ii) Within 45 days of the test, of the results of the supplemental (additional, more specific) test for HIV or HCV, as relevant, or other follow-up testing required by FDA; (iii) Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available, as set forth at 21 CFR 610.48(b)(3). (4) Quarantine of blood and blood components pending completion of testing. If the blood collecting establishment (either internal or under an agreement) notifies the hospital of the reactive HIV or HCV screening test results, the hospital must determine the disposition of the blood or	A 592		

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blood component and quarantine all blood and blood components from previous donations in inventory.

(i) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is negative, absent other informative test results, the hospital may release the blood and blood components from quarantine.

(ii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is positive, the hospital must -

(A) Dispose of the blood and blood components; and

(B) Notify the transfusion recipients as set forth in paragraph (b)(6) of this section.

(iii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is indeterminate, the hospital must destroy or label prior collections of blood or blood components held in quarantine as set fors at 21 CFR 610.46(b)(2), 610.47(b)(2), and 610.48(c)(2).

(5) Recordkeeping by the hospital. The hospital must maintain --

(i) Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval; and

(ii) A fully funded plan to transfer these records to another hospital or other entity if such hospital ceases operation for any reason.

(6) Patient notification. If the hospital has administered potentially HIV or HCV infectious

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blood or blood components (either directly through its own blood collecting establishment or under an agreement) or released such blood or blood components to another entity or appropriate individual, the hospital must take the following actions:

(i) Make reasonable attempts to notify the patient, or to notify the attending physician who ordered the blood or blood component and ask the physician to notify the patient, or other individual as permitted under paragraph (b)(10) of this section, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling.

(ii) If the physician is unavailable or declines to make the notification, make reasonable attempts to give this notification to the patient, legal guardian or relative.

(iii) Document in the patient's medical record the notification or attempts to give the required notification.

(7) Timeframe for notification.

(i) For donors tested on or after February 20, 2008. For notifications resulting from donors tested on or after February 20, 2008 as set forth at 21 CFR 610.46 and 21 CFR 610.47 the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HIV or HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification over a period of 12 weeks unless--

(A) The patient is located and notified; or

(B) The hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the hospital's control that caused the notification

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A 592	Continued From page 106 timeframe to exceed 12 weeks. (ii) For donors tested before February 20, 2008. For notifications from donors tested before February 20, 2008 as set forth at 21 CFR 610.48(b) and (c), the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification and must complete the actions within 1 year of the date on which the hospital received notification from the outside blood collecting establishment. (8) Content of notification. The notification must include the following information: (i) A basic explanation of the need for HIV or HCV testing and counseling. (ii) Enough oral or written information so that an informed decision can be made about whether to obtain HIV or HCV testing and counseling. (iii) A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose. (9) Policies and procedures. The hospital must establish policies and procedures for notification and documentation that conform to Federal, State, and local laws, including requirements for the confidentiality of medical records and other patient information. (10) Notification to legal representative or relative. If the patient has been adjudged incompetent by a State court, the physician or hospital must notify a legal representative designated in accordance with State law. If the patient is competent, but State law permits a legal representative or	A 592		

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A 592	Continued From page 107 relative to receive the information on the patient's behalf, the physician or hospital must notify the patient or his or her legal representative or relative. For possible HIV infectious transfusion recipients that are deceased, the physician or hospital must inform the deceased patient's legal representative or relative. If the patient is a minor, the parents or legal guardian must be notified. (11) Applicability. HCV notification requirements resulting from donors tested before February 20, 2008 as set forth at 21 CFR 610.48 will expire on August 24, 2015. This STANDARD is not met as evidenced by: Based on review of policy and procedures and interviews with the director of nursing and the inservice/infection control nurse, there are no policies or procedures in place for the hospital to take appropriate action when notified that blood or blood components it received are at risk of transmitting HIV or HCV. The findings include: The director of nursing interviewed on 9/25/2008 at 9:35 AM, stated the hospital had no system in place to notify recipients of receiving potentially infectious blood or blood components. This was confirmed by the inservice/infection control nurse who was interviewed on 9/25/2008 at 10:00 AM.	A 592		
A 593	482.27(c) GENERAL BLOOD SAFETY ISSUES General blood safety issues. For lookback activities only related to new blood safety issues that are identified after August 24, 2007, hospitals must comply with FDA regulations as they pertain to blood safety issues in the following areas:	A 593		

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A 593	Continued From page 108 (1) Appropriate testing and quarantining of infectious blood and blood components. (2) Notification and counseling of recipients that may have received infectious blood and blood components. This STANDARD is not met as evidenced by: Based on review of policy and procedures and interviews with the director of nursing and the inservice/infection control nurse, there are no policies or procedures in place for the hospital to take appropriate action when notified that blood or blood components it received are at risk of transmitting HIV or HCV. The findings include: The director of nursing interviewed on 9/25/2008 at 9:35 AM stated the hospital had no system in place to notify and counsel recipients about receiving potentially infectious blood or blood components. This was confirmed by the inservice/infection control nurse who was interviewed on 9/25/2008 at 10:00 AM.	A 593		
A 621	482.28(a)(2) QUALIFIED DIETITIAN There must be a qualified dietitian, full-time, part-time, or on a consultant basis. This STANDARD is not met as evidenced by: Based on review of nutrition policies and procedures, the facility failed to develop a policy to address the nutritional needs of newly admitted patients. Findings include:	A 621		

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A 621	Continued From page 109 Review of the "Nutrition for New Patients/Residents" dated 3/2006 revealed that within 72 hours a patient would be visited to determine if there were special needs. The policy did not address the acute care hospital patient that may require nutrition assessment or screening services prior to three days after being admitted to the hospital.	A 621		
A 622	482.28(a)(3) COMPETENT DIETARY STAFF There must be administrative and technical personnel competent in their respective duties. This STANDARD is not met as evidenced by: Based on observation the dietary staff failed to ensure the hospital kitchen was maintained in a clean and sanitary manner: Findings include: During the tour of the kitchen the following concerns were identified: On 9/24/08 at 9:28am, observed one dietary employee washing dishes from the breakfast meal. The employee was wearing plastic gloves. The employee was working alone in the dish washing room. The employee was observed handling the dirty dishes, clearing, stacking and loading the dishes into a tray for washing and then removing the clean dishes from the tray without changing gloves or washing his hands. This practice was observed twice before the dietary manager intervened and asked the employee to change his gloves between touching dirty and then clean dishes. Torn floor mats located on the floor in front of the stove and steam table.	A 622		

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A 622	Continued From page 110 One package of lemon pudding mix was not resealed or dated after it was opened. There was a large amount of water on the floor in the dish washing room. Staff had placed a blanket on the floor to absorb the water rather than allowing the water to drain properly into the floor drain. The floor in the walk-in freezer had broken tiles, dirt and debris had accumulated in this area.	A 622		
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the maintenance of a sanitary physical environment to control infections and diseases of patients and personnel. Findings included: On 09/23/08 at 8:00 AM, a tour of the facility was conducted. The following observations were made. 1. In shower room located in the 400 hall, feces was observed stuck to the inside of a toilet. - Two stained 2x2 dressings were seen lying on the shower room floor. - Two pairs of used discarded gloves, plastic trash, a brown stained Posey vest were located	A 749		

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A 749	Continued From page 111 on the floor. - The floor in the shower room was filthy with brown dirt stains and foot prints throughout the shower area. - The room was cluttered with equipment including numerous wheel chairs, shower chairs, tables and infection control carts. - Infection control supplies which included boxes of gloves and masks were lying on the floor by one of the carts. - The shower room contained shelves stocked with clean linen. - A sign on the door read, clean disinfected equipment only. 2. In a clean linen room located on the 100 hall a large plastic bag, a pair of latex gloves and two sheets were observed lying on the floor. 3. In a storage room located between the 100 and 300 units used for storage of dialysis machines, trash was observed overflowing from a trash bag. - An empty bleach bottle, used gloves, and plastic trash was lying on the floor. - An empty bleach bottle and a used glove was lying on top of a counter top. - A tan colored sticky substance covered the floor by two dialysis machines. 4. In the laundry room located off the main hallway of the facility, trash was overflowing from a trash container and had spilled onto the floor inside the doorway. - Black streaks, brown dirt and white powder covered the floor by the washers and dryers. - A water soaked bed cover and several water saturated towels were observed lying in a pool of water behind one of the washing machines. - Several paper cups, straws, and black stained	A 749		

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A 749	Continued From page 112 paper trash was observed floating in a pool of water behind one of the washing machines. 5. In a storage area located off the 500 hall used to store dialysis and intravenous supplies, trash was overflowing out of a trash can inside the door. - Dirt and dust covered the floor of the storage room. - A fine layer of dust could be seen on IV supplies that were stored on a bottom shelf approximately six inches from the floor. 6. In the rehabilitation area under the lid of a washing machine, brown crumbs and dirt was located around the perimeter and on top of the washer. - Wet pads were left inside the washer. On 09/23/08 at 10:30 AM, a tour of the facility was conducted with the Infection Control Nurse who acknowledged the shower room, clean linen room and dialysis storage room were not properly cleaned or disinfected by housekeeping. On 09/23/08 at 2:30 PM, the Housekeeping Supervisor reported he had taken over the job of supervising housekeeping at the facility two months ago. The Housekeeping Supervisor acknowledged he did not have the keys to get into an oxygen storage room or a storage area used to store dialysis and intravenous supplies and could not confirm the last date or time these areas were cleaned by housekeeping. The Housekeeping Supervisor acknowledged he did not know when the main laundry room was last cleaned by housekeeping. The Housekeeping Supervisor confirmed there was no written record kept of the date and time shower rooms, storage	A 749		

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A 749	Continued From page 113 rooms, linen rooms and laundry rooms were cleaned by the housekeeping staff.	A 749		
A 799	482.43 DISCHARGE PLANNING The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by: Based on interview, record review, and policies and procedures review, the facility failed to ensure policies and procedures specific to discharge planning were specified in writing. The facility failed to ensure the discharge planning included an evaluation of needed post-hospital services (A0808); failed to arrange the initial implementation for the discharge planning and services (A0820); failed to include a list of Home Health agencies (HHA) available to the patient that participated in the Medicare program and that served the geographic area in which the patient resided (A0823); failed to document in the patient's medical record that the list was presented to the patient (A0827); failed to ensure the patient's right to choose post hospital care (A828); and failed to ensure the hospital did not specify or limit the qualified providers available to the patient (A0830). The cumulative effects of these systemic practices resulted in the failure of the facility to deliver statutory mandated care to patients. Findings include: 1. Policy review: Section: Social Services: "Policy Discharge	A 799		

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A 799	Continued From page 114	A 799		

Planning and Documentation" (Standards Manual 906 012.12, most recent revision 5/05) - stated "Upon a receipt of referral from the Clinical Director, Social Services will initiate Discharge Planning document...", "upon interview and upon completion of the Discharge Planning Assessment Form, the Case Manager will issue the Discharge Planning Referral form to Social Services"; "Social Services will keep Case Management informed of discharge planning process through morning Discharge meetings, weekly Discharge meetings/rounds, bi-weekly Interdisciplinary Team Member meetings (IDT) and via Social Services chart documentation as needed.".

Another policy on discharge planning was provided (SS - 66, dated original 3/2006 - no other dates on policy): "Social Services staff, as members of the Interdisciplinary care plan team (IDCP), will participate in the development of a discharge plan for patients/residents with a potential for discharge to a private residence...."; "the discharge plan is incorporated into the patient's/resident's IDCP and addressed quarterly in Social Services progress notes.

A Case Management policy was provided (012.01CK with the most recent revision dated 9/99): "Interdisciplinary Team (ITM) meets weekly for the purpose of developing and/or reviewing the multi-disciplinary care plan for patients identified with complex levels of care"; "team will sign an attendance roster"; the Case Manager is specified as the team leader/chairperson; "the ITM chairperson will summarize the team's recommendation for either: Adjustment in the treatment plan; Adjustment in the anticipated discharge plan; or continued

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A 799	Continued From page 115 length of stay." 2. Document review Neither an ITM attendance roster, nor a summary of the ITM's recommendations were provided. Care Plans revealed no discharge plan updates. Case manager notes did not indicate the patient's discharge. 3 On 9/23/08 in the morning, the Acting Director of Nursing (DON) and Social Worker (SW) indicated the Case Manager had the ultimate responsibility for discharge. The Social Worker documented only on cases referred to her (i.e. those going into an assisted living situation or those with an unsafe discharge). They conferred the above policies were the only policies and procedures available for discharge planning. On 9/26/08 in the morning, the Case Manager (CM) confirmed the CM was the person ultimately responsible for the discharge of a patient. The CM conferred the above policies were the only policies and procedures available for discharge planning. The interviews indicated discharge planning was discussed at the "100% Reviews".	A 799		
A 808	482.43(b)(3) POST-HOSPITAL SERVICES The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. This STANDARD is not met as evidenced by:	A 808		

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A 808	Continued From page 116 Based on interview, document review, and record review the facility failed to ensure an evaluation of the needed post-hospital services and the initial implementation of post-hospital services were arranged for 5 of 36 patients (#1, #2, #3, #4, #5) Findings include: 1. Patient #1 was admitted to the facility on 12/28/08 and discharged on 1/16/08. The "Initial Admission/Discharge Demographic Verification Form" dated 12/28/07 contained: "Prior Living Arrangements", only 1 box checked (lived with spouse); nothing was checked nor written under "Prior Level of Functioning" nor under "Anticipated Discharge Plans" The patient's record did not contain an evaluation of needed post-hospital services. There were 2 Case Manager (CM) "Progress Notes" entries. The first, dated 12/31/07, "patient confused. I am waiting for her husband to visit his wife"; the second, dated 1/8/08 "12:00 spouse called regarding patients information - no response SSR (social service referral) sent." There was no evidence the referral was made as there was not a copy of the SSR in the chart nor were there any Social Services notes. The record contained 2 page 1s of the "Interdisciplinary Patient/Resident Discharge Instructions". The 2 page 1s were conflicting, they contained different medications; diet orders and physical activity comments. Neither page 1s contained a resident number and 1 of the page 1s did not contain a patient name.	A 808		

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A 808	Continued From page 117 Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" was not signed. It did not contain evidence that arrangements were made for the recommended implementation for home health (HH), physical therapy (PT) nor occupational therapy (OT) were made. The instructions did not specify if instructions were given on the recommended low salt diet. Page 2 was not signed by the patient/resident/family that the instructions were explained to her and she/they had the opportunity to ask questions. Page 2 was not signed by the employee that the patient/family was given the instructions or a telephone number to call if there were questions. There was no documented evidence arrangements were made with the primary care physician (PCP) as indicated in the Physician's Discharge Summary for follow with the PCP in 1 week. A "Interdisciplinary Plan of Care" was initiated at admit on 12/28/07. There were no updates documented, regarding discharge, in the "Interdisciplinary Plan of Care." The "Patient's Effects List" was not not completed nor signed at neither admission nor discharge. 2. Patient #2 was admitted on 8/26/07 and discharged on 9/1/07. A "Interdisciplinary Plan of Care" was initiated at admit on 8/26/07. There were no updates documented, regarding discharge, in the	A 808		

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A 808	Continued From page 118 "Interdisciplinary Plan of Care." The patient's record did not contain evidence of an evaluation of needed post-hospital services. There were 2 progress note entries by the Case Manager indicating where the patient lived prior to hospitalization (8/28/07) and the other on 9/1/07 indicating the patient was discharged to a group home and the social worker (SW) made the arrangements. There was no documented evidence in the record of the referral to social services nor was there SW documentation. The "Patient's Effects List" was not signed at discharge indicating her glasses were returned to her. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" did not contain evidence arrangements were made for the initial implementation of the recommended HH services were made. There was no documented evidence arrangements were made and the facility initiated the first appointment with the primary care physician (PCP) as indicated in the Physician's Discharge Summary for follow-up with the PCP in 1 week. 3. Patient #3 was admitted on 10/31/07 and discharged on 11/23/07. "Interdisciplinary Plan of Care" was initiated at admit on 10/31/07. There were no updates documented, regarding discharge, on the "Interdisciplinary Plan of Care."	A 808		

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A 808	Continued From page 119 The physician Orders dated 11/23/07 stated to "discharge to group home (HIC) with home health, nurse (RN), PT, OT evaluation..." Clarification HIC stands for Home for Individual Care. The social services (SS) referral form (11/9/07) indicated the daughter was trying to find placement for him in California. The "Acknowledgement of Referral" ..... to be completed by social services" was blank. There were no SS notes in the record. There was a completed "Physician's Report for Residential Care Facilities for the Elderly" for a group home in Bakersfield, California. A CM progress note dated 11/23/07 stated "Patient discharged today, he is going to (name of a group home) with Home Health (HH) order." Page 1 of the "Interdisciplinary Patient/Resident Discharge Instructions" was not signed. The instructions sheet did not specify if instructions were given on the medications or the recommended "avoid green leafy vegetables regular" diet. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" did not contain evidence if education was provided and arrangements were made for the initial implementation of the recommended HH; the 24 hour nursing hotline; the follow-up (in 3 days) with the PCP; nor the follow-up (in 1 week) with the orthopedic. Page 2 was not signed by the	A 808		

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A 808	Continued From page 120 patient/resident/family that the instructions were explained to him and he/they had the opportunity to ask questions. The "Patient's Effects List" was not not completed nor signed at neither admission nor discharge. 4. Patient #4 was admitted on 10/11/07 and discharged on 10/15/07. There was nothing documented in the patient's "Interdisciplinary Plan of Care" (dated 10/11/07) relating to Discharge planning. The patient's record did not contain an evaluation of needed post-hospital services. A CM progress note dated 10/15/07 stated "Patient discharged by physician before case management had time to see her 1200 noon". Page 1 of the "Interdisciplinary Patient/Resident Discharge Instructions" did not contain information regarding if arrangements were made for the initial implementation for physical therapy (PT) or occupational therapy (OT) were made. The instructions did not specify if instructions were given on the recommended "mechanical soft diet with nectar thick liquids and assistance with feeding" diet. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" was not in the record. There was no documented evidence arrangements were made with the primary care physician (PCP) as indicated in the Physician's Discharge Summary for the initial implementation for the follow-up with the PCP in 2 weeks.	A 808		

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A 808	Continued From page 121 The "Patient's Effects List" was not signed at discharge indicating her rings and watch were returned to her. 5. Patient #5 was admitted to the facility on 12/14/07 and discharged on 12/18/07. There was nothing documented in the patient's "Interdisciplinary Plan of Care" (dated 12/14/07) relating to Discharge planning. Page 1 of the "Interdisciplinary Patient/Resident Discharge Instructions" documented "PT, OT as tolerated". They did not contain information regarding if arrangements were made for the initial implementation for physical therapy (PT) or occupational therapy (OT) were made. The Instructions form did not specify if instructions were given on the recommended "2000 calorie American Diabetic Diet (ADA)" diet. On 9/26/08 in the morning, the Case Manager checked the closed files and the computer for further documentation on the reviewed sampled closed files. The Case Manager indicated no further documentation or information was available for the reviewed sampled closed files. Section: Social Services: "Policy Discharge Planning and Documentation" (Standards Manual 906 012.12, most recent revision 5/05) - stated "Upon a receipt of referral from the Clinical Director, Social Services will initiate Discharge Planning document...", "upon interview and upon completion of the Discharge Planning Assessment Form, the Case Manager will issue the Discharge Planning Referral form to Social Services"; "social services will keep Case	A 808		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290042	A. BUILDING _____ B. WING _____	09/26/2008

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A 808	Continued From page 122 Management informed of discharge planning process through morning Discharge meetings, weekly Discharge meetings/rounds, bi-weekly Interdisciplinary Team Member meetings (IDT) and via Social Services chart documentation as needed.". Another policy on discharge planning was provided (SS - 66, dated original 3/2006 - no other dates on policy): "Social Services staff, as members of the Interdisciplinary care plan team (IDCP), will participate in the development of a discharge plan for patients/residents with a potential for discharge to a private residence...."; "the discharge plan is incorporated into the patient's/resident's IDCP and addressed quarterly in Social Services progress notes. A Case Management policy was provided (012.01CK with the most recent revision dated 9/99): "Interdisciplinary Team (ITM) meets weekly for the purpose of developing and/or reviewing the multi-disciplinary care plan for patients identified with complex levels of care"; "team will sign an attendance roster"; the Case Manager is specified as the team leader/chairperson; "the ITM chairperson will summarize the team's recommendation for either: Adjustment in the treatment plan; Adjustment in the anticipated discharge plan; or continued length of stay." Neither an ITM attendance roster, nor a summary of the ITM's recommendations were provided.	A 808		
A 820	482.43(c)(3) IMPLEMENTATION OF A DISCHARGE PLAN The hospital must arrange for the initial implementation of the patient's discharge plan.	A 820		

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A 820	Continued From page 123 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to arrange for the initial implementation and education of the patient's discharge plan for 5 of 36 patients (#1, #2, #3, #4, #5). Findings Include: 1. Patient #1 was admittted to the facility on 12/28/07 and discharged on 1/16/08. There was no evidence the case manager (CM) made a referral to social services (SS) as specified in the CM note. A copy of the SS Referral form was not in the record nor were there any Social Services notes. The patient's record contained 2 page 1s of the "Interdisciplinary Patient/Resident Discharge Instructions". The 2 page 1s contained conflicting information: different medications were listed; different diet orders and different physical activity comments. Neither page 1s contained a resident number and 1 of the page 1s did not contain a patient name. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" did not contain evidence that arrangements were made for the recommended implementation for home health (HH), physical therapy (PT) nor occupational therapy (OT). It did not specify if instructions were given on the recommended low salt diet. Page 2 was not signed by the patient/resident/family that the instructions were explained to her and she/they had the opportunity	A 820		

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A 820	Continued From page 124 to ask questions. Page 2 was not signed by the employee that the patient/family was given the instructions or a telephone number to call if there were questions. There was no documented evidence arrangements were made with the primary care physician (PCP) as indicated in the Physician's Discharge Summary for follow-up with the PCP in 1 week. 2. Patient #2 was admitted to the facility on 8/26/07 and discharged on 9/1/07. A "Interdisciplinary Plan of Care" was initiated at admit on 8/26/07. There were no updates documented, regarding discharge, in the "Interdisciplinary Plan of Care." The patient's record did not contain evidence of an evaluation of needed post-hospital services. There were 2 progress note entries by the CM indicating where the patient lived prior to hospitalization (8/28/07) and the other on 9/1/07 indicating the patient was discharged to a group home and social services (SS) made the arrangements. There was no documented evidence in the record of the referral to social services nor was there SS documentation. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" did not contain evidence education and arrangements were made for the initial implementation of the recommended Home Health (HH) services.	A 820		

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A 820	Continued From page 125 There was no documented evidence arrangements were made were made for the initial appointment with the primary care physician (PCP) as indicated in the Physician's Discharge Summary for follow-up with the PCP in 1 week. 3. Patient #3 was admitted to the facility on 10/31/07 and discharged on 11/23/07. "Interdisciplinary Plan of Care" was initiated at admit on 10/31/07. There were no updates documented, regarding discharge, on the "Interdisciplinary Plan of Care." The physician Orders dated 11/23/07 stated to "discharge to group home (HIC) with home health, nurse (RN), PT, OT evaluation..." Clarification: HIC stands for Home for Individual Care. The social services (SS) referral form (initiated from CM on 11/9/07) indicated the daughter was trying to find placement for him in California. The "Acknowledgement of Referral" ..... 'to be completed by social services" is blank. There were no SS notes in the recrord There was a completed "Physician's Report for Residential Care Facilities for the Elderly" for a group home in Bakersfield, California. A CM progress note dated 11/23/07 stated "Patient discharged today, he is going to (name of a group home) Home Health (HH) order." Page 1 of the "Interdisciplinary Patient/Resident Discharge Instructions" was not signed. The instructions sheet did not specify if instructions	A 820		

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A 820	Continued From page 126 were given on the medications or the recommended "avoid green leafy vegetables regular" diet. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" did not contain evidence if education was provided and arrangements were made for the initial implementation of the recommended HH; the 24 hour nursing hotline; the follow-up (in 3 days) with the PCP; nor the follow-up (in 1 week) with the orthopedic. Page 2 was not signed by the patient/resident/family that the instructions were explained to him and he/they had the opportunity to ask questions. 4. Patient #4 was admitted to the facility on 10/11/07 and discharged on 10/15/07. There was nothing documented in the patient's "Interdisciplinary Plan of Care" (dated 10/11/07) relating to Discharge planning. The patient's record did not contain an evaluation of needed post-hospital services. A CM progress note dated 10/15/07 stated "Patient discharged by physician before case management had time to see her 1200 noon". Page 1 of the "Interdisciplinary Patient/Resident Discharge Instructions" did not contain information regarding if arrangements were made for the initial implementation for physical therapy (PT) or occupational therapy (OT) were made. The instructions did not specify if instructions were given on the recommended "mechanical soft diet with nectar thick liquids and assistance with feeding" diet.	A 820		

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A 820	Continued From page 127 Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" was not in the record. There was no documented evidence arrangements were made with the primary care physician (PCP) as indicated in the Physician's Discharge Summary for the initial implementation for the follow-up with the PCP in 2 weeks. 5. Patient #5 was admitted to the facility on 12/14/07 and discharged on 12/18/07. There was nothing documented in the patient's "Interdisciplinary Plan of Care" (dated 12/14/07) relating to Discharge planning. Page 1 of the "Interdisciplinary Patient/Resident Discharge Instructions" documented "PT, OT as tolerated". It did not contain information regarding education and the arrangements for the initial implementation for physical therapy (PT) or occupational therapy (OT). Page 1 did not specify if instructions were given on the recommended "2000 calorie American Diabetic Diet (ADA)." On 9/26/08 in the morning, the Case Manager, checked the closed records and the computer for further documentation on the reviewed sampled closed records. The Case Manager indicated no further documentation or information was available for the reviewed sampled closed records. The case manager indicated the facility utilized 1 home health agency for post-hospital care and did not provide a list of HHA providers.	A 820		

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A 820	Continued From page 128 The CM reported she did not make the the appointment with the HHA. The Case Manager reported she faxed a referral to the agency and gave the patient the HHA telephone number. The Case Manager indicated it was then the responsibility of the HHA and/or the patient to ensure an appointment.	A 820		
A 823	482.43(c)(6) LIST OF HOME HEALTH AGENCIES The hospital must include in the discharge plan a list of (HHAs or) SNFs that are available to the patient, that are participating in the Medicare program, and (that serve the geographic area (as defined by the HHA) in which the patient resides, or) in the case of a SNF, in the geographic area requested by the patient. (HHAs must request to be listed by the hospital as available.) This STANDARD is not met as evidenced by: Based on interview, policy review, and record review the facility failed to ensure a list of home health agencies (HHAs) were provided, as part of the discharge plan, for consideration of continued post-hospital services for 3 of 36 patients (#1, #2, #3). Findings include: Three of the 5 Closed cases reviewed had home health as a recommendation with discharge. There was no evidence the patients were given a list of possible Medicare providers. 1. Patient #1 was admitted to the facility on 12/28/07 and discharged on 1/16/08. The Physicians Discharge Summary (10/16/08)	A 823		

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A 823	Continued From page 129 stated "... transferred to a group home with home health follow-up...." Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" was not signed. It did not contain evidence a list of home health (HH) agencies was provided. There was no documented evidence in the Progress Notes a list of HHAs was provided to the patient. 2. Patient #2 was admitted to the facility on 8/26/07 and discharged on 9/1/07. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" listed home Health under the "Notifications/Arrangements, made before discharge". There was no documented evidence a list of HH agencies was provided. There was no documented evidence in the Progress Notes a list of HHAs was provided to the patient. 3. Patient #3 was admitted to the facility on 10/31/07 and discharged on 11/23/07. The physician Orders dated 11/23/07 stated to "discharge to group home (HIC) with home health, nurse (RN), PT, OT evaluation..." Clarification HIC stands for Home for Individual Care. A CM progress note dated 11/23/07 stated "Patient discharged today, he is going to (name of the group home) with Home Health (HH) order." There was no documented evidence in the	A 823		

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A 823	Continued From page 130 Progress Notes a list of HHAs was provided to the patient. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" did not contain evidence a list of HH agencies was provided. The Discharge Plan Policies and Procedures the facility provided were: 1. Section: Social Services: "Policy Discharge Planning and Documentation" (Standards Manual 906 012.12, most recent revision 5/05); 2. "SS - 66", dated original 3/2006 - no other dates on policy; 3. 012.01CK with the most recent revision dated 9/99). None of the policies included procedures for making available and included in the discharge planning process a list of participating Medicare HHAs or SNFs (skilled nursing facilities) providers. On 9/24/08 at 2:00 PM, the Acting Director of Nursing (DON) and Social Worker (SW) indicated the Case Manager had the ultimate responsibility for discharge. The Social Worker documented only on cases referred to her (i.e. those going into an assisted living situation or those with an unsafe discharge). They confirmed the above policies were the only policies and procedures available for discharge planning. On 9/26/08 in the morning, the Case Manager (CM), confirmed the CM was ultimately responsible for the discharge of a client. The Case Manager confirmed the above listed policies were the only policies and procedures available for discharge planning.	A 823		

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A 823	Continued From page 131 The Case Manager indicated the facility utilized 1 home health agency for post-hospital care and did not provide a list of HHA providers. The Case Manager indicated a list of Home Health agencies nor a list of SNF were provided. The Case Manager indicated the list of providers was not a part of the discharge planning process. The CM reported she did not make the the appointment with the HHA. The Case Manager reported she faxed a referral to the agency and gave the patient the HHA telephone number. The Case Manager indicated it was then the responsibility of the HHA and/or the patient to ensure an appointment.	A 823		
A 827	482.43(c)(6)(iii) DISCHARGE PLANNING DOCUMENT The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf. This STANDARD is not met as evidenced by: Based on record review and interview the hospital failed to document if a list of home health agencies and skilled nursing facilities was provided to the patient or to the individual acting on the patient's behalf for 3 of 36 patients (#1, #2, #3). Findings include: 1. Patient #1 was admitted to the facility on 12/28/07 and discharged on 1/16/08. The Physicians Discharge Summary (10/16/08) stated "... transferred to a group home with home	A 827		

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A 827	Continued From page 132 health follow-up...." Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" was not signed. It did not contain documented evidence a list of home health (HH) agencies was provided. There was no documented evidence in the Progress Notes a list of HHAs was provided to the patient. 2. Patient #2 was admitted to the facility on 8/26/07 and discharged on 9/1/07. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" listed home Health under the "Notifications/Arrangements, made before discharge". There was no documented evidence a list of HH agencies was provided. There was no documented evidence in the Progress Notes a list of HHAs was provided to the patient. 3. Patient #3 was admitted to the facility on 10/31/07 and discharged on 11/23/07. The physician Orders dated 11/23/07 stated to "discharge to group home (HIC) with home health, nurse (RN), physical therapy (PT), occupational therapy (OT) evaluation ..." Clarification HIC stands for Home for Individual Care. A CM progress note dated 11/23/07 stated "Patient discharged today, he is going to (name of group home) with Home Health (HH) order." There was no documented evidence in the	A 827		

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A 827	Continued From page 133 Progress Notes a list of HHAs was provided to the patient. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" did not contain evidence a list of HH agencies was provided. The Discharge Plan Policies and Procedures the facility provided were: 1). Section: Social Services: "Policy Discharge Planning and Documentation" (Standards Manual 906 012.12, most recent revision 5/05); 2). "SS - 66", dated original 3/2006 - no other dates on policy; 3). 012.01CK with the most recent revision dated 9/99). None of the policies included procedures for ensuring documenting, in the medical record, that a list of participating Medicare HHAs or SNFs (skilled nursing facilities) providers was provided to the patient or the person acting on the patient's behalf prior to discharge. On 9/24/08 at 2:00 PM, the Acting Director of Nursing (DON) and Social Worker (SW) indicated the Case Manager had the ultimate responsibility for discharge. The Social Worker documented only on cases referred to her (i.e. those going into an assisted living situation or those with an unsafe discharge). They confirmed the above policies were the only policies and procedures available for discharge planning. On 9/26/08 in the morning, the Case Manager (CM) confirmed the CM was ultimately responsible for the discharge of a client. The Case Manager confirmed the above listed policies were the only policies and procedures available for discharge planning.	A 827		

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A 827	Continued From page 134 The Case Manager indicated the facility did not provide a list of HH agencies nor a list of SNF. The Case Manager indicated the list of providers was not a part of the discharge planning process. The Case Manager indicated the facility utilized 1 home health agency for post-hospital care and did not provide a list of HHA providers. The Case Manager indicated the list of providers was not a part of the discharge planning process. The CM reported she did not make the the appointment with the HHA. The CM reported she faxed a referral to the agency and gave the patient the HHA telephone number. The CM indicated it was then the responsibility of the HHA and/or the patient to ensure an appointment was made.	A 827		
A 828	482.43(c)(7) FREEDOM TO CHOOSE FACILITIES The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services, and... This STANDARD is not met as evidenced by: Based on record review and interview the hospital failed to, as part of the discharge planning process, inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services for 3 of 36 patients (#1, #2, #3). Findings include: 1. Patient #1 was admitted to the facility on	A 828		

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A 828	Continued From page 135 12/28/07 and discharged on 1/16/08. The Physicians Discharge Summary (10/16/08) stated "... transferred to a group home with home health follow-up...." Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" was not signed. It did not contain documented evidence a list of home health (HH) agencies was provided. There was no documented evidence in the Progress Notes a list of HHAs was provided to the patient. 2. Patient #2 was admitted to the facility on 8/26/07 and discharged on 9/1/07. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" listed home Health under the "Notifications/Arrangements, made before discharge". There was no documented evidence a list of HH agencies was provided. There was no documented evidence in the Progress Notes a list of HHAs was provided to the patient. 3. Patient #3 was admitted to the facility on 10/31/07 and discharged on 11/23/07. The physician Orders dated 11/23/07 stated to "discharge to group home (HIC) with home health, nurse (RN), physical therapy (PT), occupational therapy (OT) evaluation ..." Clarification HIC stands for Home for Individual Care. A CM progress note dated 11/23/07 stated	A 828		

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	290042	A. BUILDING _____ B. WING _____	09/26/2008

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A 828	Continued From page 136 "Patient discharged today, he is going to (name of group home) with Home Health (HH) order." There was no documented evidence in the Progress Notes a list of HHAs was provided to the patient. Page 2 of the "Interdisciplinary Patient/Resident Discharge Instructions" did not contain evidence a list of HH agencies was provided. The Discharge Plan Policies and Procedures the facility provided were: 1. Section: Social Services: "Policy Discharge Planning and Documentation" (Standards Manual 906 012.12, most recent revision 5/05); 2. "SS - 66", dated original 3/2006 - no other dates on policy; 3. 012.01CK with the most recent revision dated 9/99). None of the policies included procedures, as part of the discharge planning process, for ensuring the facility informed the patient or the person acting on the patient's behalf that they had the freedom to choose for post-hospital care. On 9/26/08 in the morning, the Case Manager (CM) indicated the CM was responsible for the discharge of a client. She The CM indicated the above listed policies were the only policies and procedures available for discharge planning. The Case Manager indicated the facility did not provide a list of HH agencies nor a list of Skilled Nursing Facilities (SNF). The CM indicated the list of providers was not a part of the discharge planning process.	A 828		

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A 828	Continued From page 137 The Case Manager indicated the facility utilized 1 home health agency for post-hospital care and did not provide a list of HHA providers. The CM indicated the list of providers was not a part of the discharge planning process.	A 828		
A 830	482.43(c)(7) COMPLETE LIST OF QUALIFIED PROVIDERS The hospital must not specify or otherwise limit the qualified providers that are available to the patient. This STANDARD is not met as evidenced by: Based on policy review and interviews the hospital failed to ensure they did not specify or otherwise limit the qualified providers that were available to patients. Findings include: The Discharge Plan Policies and Procedures the facility provided were: 1. Section: Social Services: "Policy Discharge Planning and Documentation" (Standards Manual 906 012.12, most recent revision 5/05); 2, "SS - 66", dated original 3/2006 - no other dates on policy; 3. 012.01CK with the most recent revision dated 9/99). None of the policies included procedures to ensure the facility did not specify or limit the qualified providers available to the patient for post-hospital care. On 9/24/08 at 2:00 PM, the Acting Director of Nursing (DON) and Social Worker (SW) indicated the above policies were the only policies and procedures available for discharge planning.	A 830		

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A 830	Continued From page 138 On 9/26/08 in the morning, the Case Manager confirmed the CM was ultimately responsible for the discharge of a client. The CM confirmed the above listed policies were the only policies and procedures available for discharge planning. The CM indicated the facility did not provide a list of HH agencies nor a list of Skilled Nursing Facilities (SNF). The CM indicated the list of providers was not a part of the discharge planning process. The CM indicated the facility refers all patients to 1 Home Health Agency. Only one provider was utilized.	A 830		
A 885	482.45(a) WRITTEN POLICIES AND PROCEDURES The hospital must have and implement written protocols that: This STANDARD is not met as evidenced by: Based on policy and procedure review and administrator interview the facility failed to incorporate an agreement with an organ procurement organization (OPO). Findings include: On 9/24/08 at 11:00 AM, the Hospital Administrator reported the facility did not have a written agreement with an organ procurement organization (OPO).	A 885		
A 887	482.45(a)(2) TISSUE AND EYE BANK AGREEMENTS Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in	A 887		

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A 887	Continued From page 139 the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement; This STANDARD is not met as evidenced by: Based on an interview with the hospital administrator, the facility failed to have an agreement with one tissue and one eye bank. Findings: On 9/24/08, the hospital administrator reported the facility did not have an agreement with an organ procurement organization providing tissue and eye bank referrals.	A 887		
A 891	482.45(a)(5) STAFF EDUCATION Ensure that the hospital works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues; This STANDARD is not met as evidenced by: Based on policy and procedure review and staff interview, the facility failed to educate the hospital staff regarding organ, tissue and eye donation issues. Findings include: Review of the facility policy and procedure entitled " Organ Tissue, Eye And/Or Cornea Donation " revised 9/06 revealed " All Nursing Personnel will be aware of the general criteria for cadaver organ donation and actively participate in the procurement process if indicated ." On 9/22/08 at 10:30 AM, Charge Nurse #12 was interviewed. The Charge Nurse did not know if	A 891		

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A 891	Continued From page 140 there was a policy addressing organ procurement and did not know what her responsibilities were regarding organ procurement. The Charge Nurse did not know how she could tell if a patient was a donor. On 9/22/08, Charge Nurse #14 was interviewed. The Charge Nurse was aware the nursing admission interview form contained a question regarding organ donation. The Charge Nurse reported the form entitled " Release of Body Authorization " contained a section where the nurse had to indicate if an organ service recovery service was notified and if the patient was an organ or tissue donor. The Charge Nurse stated she did not know if imminent death was a reason to call an organ procurement organization. The Charge Nurse did not know if there was a policy and procedure that addressed organ procurement. On 9/22/08, the Inservice/Infection Control Nurse #4, was interviewed. The nurse was not aware of the organ procurement policy. The nurse reported the nurses were not trained in regard to organ, tissue or eye donation as part of their orientation or part of an ongoing inservice program.	A 891		